SEVENTH EDITION

INTRODUCTION TO THE COUNSELING PROFESSION

Edited by David Capuzzi & Douglas R. Gross

INTRODUCTION TO THE COUNSELING PROFESSION

Designed for students who are taking a preliminary course in the counseling field, *Introduction to the Counseling Profession, 7th Edition* provides a comprehensive overview of the history and foundational concepts of counseling, offering the most current and relevant breadth of coverage available from experts in their respective fields. This edition includes topics rarely discussed in introductory texts, such as self-care and self-growth and the use of technology in counseling, as well as a new chapter on crisis counseling. Chapters also reflect updates to the 2016 Council for the Accreditation of Counseling and Related Educational Programs (CACREP) standards, and a chapter on each CACREP specialization is included.

Students will gain insight into the myriad issues that surround not only the process of counseling and its many populations but also the personal dynamics that have an impact on this process. Furthermore, a collection of supplemental resources is available online to benefit both instructors and students. Instructors will find PowerPoint slides and test banks to aid in conducting their courses, and students can access chapter summaries, exercises, and other tools to supplement their review of the material in the text.

David Capuzzi, PhD, NCC, LPC, is a senior core faculty member in clinical mental health counseling at Walden University and professor emeritus at Portland State University. He is past president of the American Counseling Association (ACA) and past chair of both the ACA Foundation and the ACA Insurance Trust. He is coauthor/editor of ten counselor education textbooks.

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PREFACE

The profession of counseling is best described as one through which counselors interact with clients to assist them in learning about and dealing with themselves and their environment and the roles and responsibilities inherent in this interactive process. Individuals exploring counseling as a career choice need to be aware of the personal, professional, and societal demands placed on the professional counselor. The role of the professional counselor calls for individuals who are skilled and knowledgeable in the processes and theories that undergird the profession, who are able and willing to reach deeper levels of self-understanding, and who are able to integrate this skill, knowledge, and self-understanding to provide the effective counseling interaction to which clients are entitled. Individuals attempting to decide whether this is the right career choice for them will find the information contained in the text helpful in the decision-making process.

The book is unique both in its format and in its content. The contributed author format provides state-of-the-art information by experts in their respective fields. The content provides readers with areas not often addressed in introductory texts. Examples of these areas include chapters devoted to self-care and self-growth, the use of technology in counseling, and a one of a kind chronicling of the history of the profession and current issues and trends. The book is designed for students who are taking a preliminary course in the counseling field and who are trying to determine if they are well matched to the profession of counseling. It also meets the professional orientation expectation of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and is a perfect fit for an introduction to counseling or orientation to counseling course. The book presents a comprehensive overview of the major aspects of counseling as a profession and provides readers with insight into the myriad issues that surround not only the process of counseling and its many populations but, also, the personal dynamics of the counselor that have an impact on this process.

Overview of the Seventh Edition

This seventh edition of our text is congruent with the 2016 standards of CACREP and addresses core curricular areas specified by CACREP so that beginning counselors can obtain overviews of the knowledge and skills they must master as they progress through their graduate programs of study. In addition, the last six chapters of the seventh edition

overview all the specializations CACREP now accredits: addictions counseling, career counseling, clinical mental health counseling, clinical rehabilitation counseling, marriage, couples, and family counseling, school counseling, and student affairs and college counseling. More discussion of the implications of counseling with diverse populations, additional case studies, sidebars, and a number of new authors add freshness and dimension to this new edition. Both format and content enhance the readability of the book and should increase student interest in the material.

We know that one text cannot adequately address all the factors that make up this complex profession. We have, however, attempted to provide our readers with a broad perspective on the profession of counseling. The text is divided into the following three sections: Counseling Foundations, Counseling Approaches and Practices, and Counseling Specializations. Part I, Counseling Foundations (chapters 1 through 5), begins with a chapter dealing with *The Counseling Profession: Historical Perspectives and Current Issues and Trends* that chronicles the historical foundation of the counseling profession; it then builds on this foundation providing the reader with current information regarding legislation, professional associations, certification, licensure, accreditation, and current issues and trends related to counseling. Chapters entitled *Counseling Across Cultures*; *Ethical and Legal Considerations in Counseling*; *Self-Care and Self-Growth: A Professional Responsibility*; and *Technology in Counseling* follow. Part II, Counseling Approaches and Practices (chapters 6 through 12), presents information relative to the skills counselors must acquire through a combination of education, supervision, and practice. These chapters include: *The Therapeutic Alliance and the Helping Relationship*; *Individual Counseling: Traditional and Brief Approaches*; *Group Counseling*; *Creative Approaches to Counseling*; *Assessment in Counseling*; *Diagnosis and Treatment Planning*; and *Crisis and Natural Disaster Counseling*. All of these chapters provide overviews and introduce readers to roles that cut across a variety of work settings. Part III, Counseling Specializations (Chapters 13 through 19), presents information relative to the seven specializations now accredited by CACREP. These chapters include discussions of the content outlined in the current standards for those specializations: *Addictions Counseling*; *Career Counseling*; *Counseling in Clinical Mental Health and Private Practice Settings*; *Clinical Rehabilitation Counseling*; *Marriage, Couples, and Family Counseling*; *School Counseling*; and *College Counseling and Student Affairs*.

New to this Edition

This edition of our text is based on both post publication reviews of the sixth edition and the desire of the co-editors to update content, enhance reader interest by using sidebars and additional case studies, and make the reading even more user friendly.

Chapter 1 (*The Counseling Profession: Historical Perspectives and Current Issues and Trends*) provides historical and updated information about the profession, major professional organizations, and new developments that inform the reader about current issues and trends.

Chapter 2 (*Counseling Across Cultures*) is a revised chapter for this seventh edition. Since it is the co-editors' philosophy that all counseling is across cultures in nature, it is a critical component of the education and supervision of a counselor.

Chapter 3 (*Ethical and Legal Considerations in Counseling*) has been rewritten and updated and contains a number of interesting sidebars and case studies that will be of high interest to the reader.

Chapter 4 (*Self-Care and Self-Growth: A Professional Responsibility*) was written at the request of the editors, was new to the sixth edition, and has been thoroughly updated. This chapter provides information that is crucial to the beginning counselor entering a

profession that places huge responsibility on its members that often precipitates burnout, impairment, or both. It is the hope of the editors that readers will view this chapter as preventive in intent and will periodically review its content.

Chapter 5 (*Technology in Counseling*) is critical to the successful functioning of the twenty-first century counselor. The updated information, addition of sidebars and case studies, and expertly written and organized content provides the most up to date information possible to prepare the counselor for the crescendo in the use of technology in the counseling profession.

Chapter 6 (*The Therapeutic Alliance and the Helping Relationship*) has been updated so that the reader has access to the most current information on this topic.

Chapter 7 (*Individual Counseling: Traditional and Brief Approaches*) provides major revisions for the seventh edition. Readers are introduced to traditional theoretical frameworks for individual counseling and some follow up examples of how they may be used in brief counseling. Case studies and interesting tables and sidebars make this a very user-friendly chapter that is easy to assimilate.

Chapters 8, 9, and 10 (*Group Counseling*, *Creative Approaches to Counseling*, and *Assessment in Counseling*) have all been updated with sidebars, case studies, and current information that make each of them even more useful to the beginning professional counselor.

Chapter 11 (*Diagnosis and Treatment Planning*) incorporates the newest version of the DSM. We think readers will find the author's approach to the topic current, refreshing, and congruent with the emphasis on resilience and health and wellness inherent in the counseling profession.

Chapter 12 (*Crisis and Natural Disaster Counseling*) is entirely new and extremely pertinent to the role of the current day counselor given the myriad of shootings and natural crises that have been escalating in number.

Chapters 13 through 19 (*Addictions Counseling*, *Career Counseling*, *Counseling in Clinical Mental Health and Private Practice Settings*, *Clinical Rehabilitation Counseling*, *Marriage, Couples, and Family Counseling*, *School Counseling*, and *College Counseling and Student Affairs*) have all been updated. One chapter (*Clinical Rehabilitation Counseling*) is new to the seventh edition of our text. Each of the seven chapters has been organized to be congruent with the CACREP standards and follow the CACREP-specified content that counselors must receive if the specializations are to be CACREP accredited. The co-editors believe that this is the only introductory textbook containing chapters organized in such manner.

Finally, this seventh edition provides faculty members with a comprehensive set of ancillary materials that can be used for instructional purposes. They include PowerPoints for each chapter, test items, chapter summaries, exercises that can be used as assignments, etc. We think these ancillaries are a welcome component to our textbook and will enable faculty to use their time and expertise to develop other ways to enhance the instructional experience for students.

Every attempt has been made by the editors and contributors to provide the reader with current information in each of the 19 chapters. It is our hope that *Introduction to the Counseling Profession* (7th ed.) will provide the neophyte with the foundation needed to make a decision regarding future study in the professional arena of counseling.

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We would like to thank the authors who contributed their time, expertise, and experience to the development of the seventh edition of this textbook for the new professional. We would also like to thank our families, who provided the support to make our writing and editing efforts possible. Our thanks are also directed to the staff of Routledge for their creativity, encouragement, and editing skills.

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David Capuzzi, PhD, NCC, LPC, is a counselor educator and member of the core faculty in mental health counseling at Walden University and professor emeritus at Portland State University. Previously, he served as an affiliate professor in the Department of Counselor Education, Counseling Psychology, and Rehabilitation Services at Pennsylvania State University and scholar in residence in counselor education at Johns Hopkins University. He is past president of the American Counseling Association (ACA), formerly the American Association for Counseling and Development, and past chair of both the ACA Foundation and the ACA Insurance Trust.

From 1980 to 1984, Dr. Capuzzi was editor of *The School Counselor*. He has authored a number of textbook chapters and monographs on the topic of preventing adolescent suicide and is co-editor and author, with Dr. Larry Golden, of *Helping Families Help Children: Family Interventions with School Related Problems* (1986) and *Preventing Adolescent Suicide* (1988). He co-authored and edited, with Douglas R. Gross, *Youth at Risk: A Prevention Resource for Counselors, Teachers, and Parents* (1989, 1996, 2000, 2004, 2008, and 2014), *Introduction to the Counseling Profession* (1991, 1997, 2001, 2005, 2009, and 2013), *Introduction to Group Work* (1992, 1998, 2002, 2006, and 2010), and *Counseling and Psychotherapy: Theories and Interventions* (1995, 1999, 2003, 2007, and 2011). Other texts are *Approaches to Group Work: A Handbook for Practitioners* (2003), *Suicide Across the Life Span* (2006), and *Sexuality Issues in Counseling,* the last co-authored and edited with Larry Burlew. He has authored or co-authored articles in a number of ACA-related journals.

A frequent speaker and keynoter at professional conferences and institutes, Dr. Capuzzi has also consulted with a variety of school districts and community agencies interested in initiating prevention and intervention strategies for adolescents at risk for suicide. He has facilitated the development of suicide prevention, crisis management, and postvention programs in communities throughout the United States; provides training on the topics of youth at risk and grief and loss; and serves as an invited adjunct faculty member at other universities as time permits.

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Dr. Gross has contributed chapters to seven textbooks: *Counseling and Psychotherapy: Theories and Interventions* (1995, 1999, 2003, 2007, 2011), *Youth at Risk: A Resource Guide for Counselors, Teachers and Parents* (1989, 1996, 2000, 2004, 2008, and 2014), *Foundations of Mental Health Counseling* (1986, 1996), *Counseling Theory, Process, and Practice* (1977), *The Counselor's Handbook* (1974), *Introduction to the Counseling Profession* (1991, 1997, 2001, 2005, 2008, and 2013), and *Introduction to Group Work* (1992, 1998, 2002, 2006, and 2010). His research has appeared in the *Journal of Counseling Psychology*, *Journal of Counseling and Development*, *Association for Counselor Education and Supervision Journal*, *Journal of Educational Research*, *Counseling and Human Development*, *Arizona Counselor's Journal*, *Texas Counseling Journal*, and the *AMHCA Journal*.

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Ann Vernon, PhD, LPC, is professor emerita, University of Northern Iowa, where she served as an elementary counselor at the university laboratory school for 10 years before becoming the coordinator of the School and Mental Health Counseling programs, a position she served in for 23 years. In addition to her university appointment, Dr. Vernon was in private practice, working with children and adolescents as well as couples and individuals. Dr. Vernon is the president of the Albert Ellis Board of Trustees and former director of the Midwest Center for REBT. She is recognized as the leading international expert in applications of RE and CBT with children and adolescents and currently conducts training courses in several countries on this topic. Dr. Vernon has written 22 books and over 75 journal articles and chapters on a variety of topics. She is also the editor of *Counseling Children and Adolescents*, a textbook that is used throughout the country and in other parts of the world in many counselor education programs. In addition to being one of the first diplomates of the Albert Ellis Institute, Dr. Vernon has received numerous awards for her contributions to the counseling profession and was the originator of the ACES Women's Retreats.

Elina Zalkalne, MA, is a counselor working primarily with school children. She graduated from the University of Malta with a bachelor's degree in psychology having presented a dissertation on the coping mechanisms of ER doctors and nurses. Her interest in this field led her to pursue further studies through an innovative program offered by the same university in conjunction with the University of New Orleans. She was recently awarded a Master of Arts in transcultural counseling, summa cum laude, focusing on color-consciousness and racial identity. At present, she works within the Maltese Ministry of Education and Employment as a school counselor. A large portion of her work includes community outreach and advocating for minorities. She is extremely passionate about her work, and continuously draws upon personal experiences and her own education to provide the best care possible for her clients. Despite being Latvian born, she has put down her roots in Malta but considers herself a national of the world. A keen reader and adventurer, she finds herself constantly challenging her own perceptions and opinions in search of self-betterment.

Part I

COUNSELING FOUNDATIONS

1

THE COUNSELING PROFESSION

Historical Perspectives and Current Issues and Trends

Harriet L. Glosoff, Jill E. Schwarz, and Stephanie A. DiZenzo-Priestley[1]

Historical and Formative Factors

If one assumes that counseling is advising, counselors have existed since people appeared on Earth. Mothers, fathers, friends, lovers, clergy, and social leaders all provide such counsel—whether sought after or not. The idea of professional counseling, defined by the American Counseling Association (ACA, n.d.), as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" is relatively new. The counseling profession evolved in response to the demands made by the industrialization and urbanization of the United States. At the turn of the twentieth century, America faced a confluence of social and economic problems, such as the proper distribution of a growing workforce, an increasingly educated population, the needs of immigrants, and the preservation of social values as family connections were weakened (Herr, 1985).

A representative democracy demands an educated citizenry that takes responsibility for the government itself. As the new democracy developed, so did the ideal of education for all citizens. Toward the end of the nineteenth century, the curriculum of schools began to change, and choices among school subjects became available. Help with such choices was necessary. Jesse Davis, one of the pioneers in counseling, declared in his autobiography that he had graduated from school "fairly well prepared to live in the Middle Ages" (Davis, 1956, p. 57). His experiences led directly to the establishment of guidance and counseling services in schools. There were other societal factors that contributed to the evolution of requiring professional training for those in positions to help people. For example, the industrial revolution and its attendant job specialization and technological advances added pressure to understand how to best help people make career choices. There was also an increase in democracy after the Civil War ended in 1865. If the United States had continued to exist as a slave society or a closed class society, there probably would have been little need for the development of counseling services.

The population of the country was on the increase, and the census of 1890 revealed that the frontier was essentially closed. Larger cities were growing increasingly more crowded, and immigrants to the United States and other citizens could no longer move westward without regard for others. "Free" land was all but gone. It became necessary to remain near the cities to work, to live, and to get along with one's neighbors. People needed

assistance in making decisions about what was involved in being able to live in the large industrially based cities.

During the twentieth century, the development of professional counseling in the United States was influenced by a variety of factors. The newly developed science of psychology began, and continued, studying the differences among individuals. Instruments for appraising people were in their infancy but were known to pioneers in the field, who noted the need for counseling services. As these tools developed more sophistication, they were adapted or adopted by counselors. There were other factors that contributed to the evolution of counseling, such as: the work of leaders of the early settlement house movement and other social reformers; the mental hygiene movement; the extent to which Americans value personal success; the emphasis placed on the awareness and use of one's talents, interests, and abilities; the ongoing industrialization of the country; the continued growth of career education and career guidance; the development of psychology as a profession; and the rapid changes in all fields due to increased availability of technology (Shertzer & Stone, 1986).

Pressures from various socioeconomic factors also led to the kaleidoscope we know as counseling today. The history of counseling has continued the thread of individual choice in a society that prizes freedom to choose as an ideal. Like a kaleidoscope, the form, emphasis, and brightness of various aspects of counseling have changed as society changes. In this chapter, we examine the following select facets of that kaleidoscope which have shaped the counseling profession:

- The vocational guidance movement.
- The mental health counseling movement.
- The ongoing development of professional identity.
- The influence of federal legislation.
- The history of the American Counseling Association.
- Credentialing and the "professionalization" of counseling.

The chapter concludes with a brief review of current issues and trends in the counseling profession.

Beginnings of the Vocational Guidance Movement

Perhaps the earliest notion of professional counseling in response to societal pressures was that of Lysander S. Richards. In 1881, Richards published a slim volume titled *Vocophy*. He considered vocophy to be a "new profession, a system enabling a person to name the calling or vocation one is best suited to follow" (Richards, 1881). Although scholars have dismissed his work because there is no documented proof that he established the services he advocated, his ideas foreshadowed what was to come. He called his counselors "vocophers" and urged that they study occupations and the people they counseled. Richards believed that aspirants to particular occupations should consider what successful people had to say about the qualifications for success in that field.

Whether Richards influenced those who followed is speculative. Influence is the quicksilver of history. He was active in the literary societies in the Boston area, as was Frank Parsons. Did they meet? Did they debate? Richards's *Vocophy* was in the Harvard Library in the 1890s. In an article published in the later 1890s, Parsons (1894) expressed ideas similar to those of Richards. Brewer (1942) noted that Meyer Bloomfield, a colleague

of Parsons at the Breadwinners Institute, mentioned Richards in his Harvard courses, as did Henry C. Metcalf of Tufts and Frank Locke of the YMCA in Boston.

Frank Parsons

Regardless of who influenced whom, the need for counseling about vocational choice seemed to have permeated American society of the late nineteenth and early twentieth centuries. There is no question of the credit given to Frank Parsons for leading the way to vocational guidance. Parsons had a long history of concern for economic and political reforms that would benefit people. He published books and articles on a wide variety of topics, including taxation, women's suffrage, and education for all people. Of all his endeavors, Parsons was most interested in social reform and especially in assisting people to make sound occupational choices. Other pioneers in the field credited him with being the first counselor (Davis, 1914; Reed, 1944), and have often referred to him as the "father of guidance." Parsons alone, of those individuals who had some direct connection with the organization and extension of guidance services, had a definite, well-thought-out, and organized social philosophy, which he articulated often and at length (Rockwell, 1958).

Parsons believed it was better to select a vocation scientifically than to drift through a variety of vocations, perhaps never finding one that would be best for the person and, thus, make society better. Meyer Bloomfield, director of the Civic Service House in Boston, asked Parsons to establish such a service within the Civic Service House. Thus, Parsons became director of what was called the Breadwinners Institute from 1905 through 1907 (Brewer, 1942).

Parsons developed a plan for individualized counseling and opened the Vocational Bureau of Boston in January 1908. He served as its director and vocational counselor. The primary goal of the Bureau was to develop the potential of Boston's growing immigrant population. Although Parsons was but one of many individuals seeking social reforms at that time, he was able to secure the support of the leaders of powerful groups in business, labor, education, and politics. His report to the members of the board controlling the Vocational Bureau was the first recorded instance of the use of the term *vocational guidance* (Brewer, in 1942, published the report as an appendix to his *History*). Parsons' report emphasized that counseling was not designed to make decisions for counselees. "No attempt is made, of course, to decide FOR [*sic*] the applicant what his calling should be; but the Bureau tries to help him arrive at a wise, well-founded conclusion for himself" (Brewer, 1942, p. 304). According to Williamson (1965), this was consistent with the moral and intellectual atmosphere of that time. He traced the growth of counseling before Parsons' work to the concept of "vocational freedom of choice" (p. 3). He noted that the climate of the late 1800s stimulated the practical application of vocational choice or individuals' freedom to pursue choice in personal development.

Parsons also developed a plan for the education of counselors, which he outlined in his book *Choosing a Vocation* (1909), published posthumously. Parsons' systematic approach to helping people make vocational choices laid a foundation for the trait-theory of career counseling (Erford, 2014). Also, Parsons' prescriptions for how counselees should examine themselves and their lives reflected his political and social philosophy (Rockwell, 1958).

Early Ties Between Vocational Guidance and School Counseling

Many see educational settings as the first homes to the profession of counseling, especially regarding vocational guidance. In 1898, at about the same time that Parsons opened the

Vocational Bureau, Jesse Davis began advising students about educational and vocational matters (Aubrey, 1982). Jesse B. Davis had been unsure of what he wanted to do with his life throughout his educational career. He was questioned thoroughly by Charles Thurber, one of his professors at Cornell University, and that left a lasting impression on him. He began to use the professor's methods in his work with students at the Central High School in Detroit and attempted to incorporate guidance into the normal educational experience of students. In 1907, Davis became principal of the Grand Rapids, Michigan, Central School and was able to implement his ideas of self-study, occupational study, and examination of self in relation to the chosen occupation throughout the 7th through 12th grades (Brewer, 1942). This self-examination was done primarily through essays written in English classes. Essay topics varied from self-examination of values and ideals to the selection of a vocation by the 12th grade. Throughout the topics, teachers emphasized social and civic ethics (Davis, 1914). Just 5 years later (1912) Grand Rapids established a citywide guidance department.

Grand Rapids was not the only city in the early 1900s that housed newly developed vocational guidance services. Both Anna Y. Reed in Seattle and Eli Weaver in New York established counseling services based on Social Darwinian concepts (Rockwell, 1958). Similar to Darwin's biological theory of "survival of the fittest," Social Darwinism contends that certain groups in a society become powerful because they have adapted best to the evolving requirements of that society. Reed decided that America's youth needed counseling services through her study of newsboys, penal institutions, and charity schools. She emphasized that business people were the most successful and counseling should be designed to help youth emulate them. She equated morality and business ideals and was much concerned that whatever course of action an individual took on any social question should be based on social research, on the economy, and of how leaders in the business world would accept the action. Reed urged that schools keep children focused on the potential for making money, which she believed every pupil could understand (Reed, 1916).

The guidance services that Reed developed were similar to those of modern placement agencies that focus on an individual's acceptability to employers. Other programs, she said, "savored too much of a philanthropic or social service proposition and too little of a practical commercial venture" (Reed, 1920, p. 62).

Eli Weaver also believed in working within the framework of the existing society and looked at counseling as a means of keeping the wheels of the machinery well oiled. He was chairman of the Students' Aid Committee of the High School Teachers' Association of New York in 1905. In developing the work of his committee, Weaver concluded that the students were in need of advice and counsel before their entrance into the workaday world. He had no funds or active help from school authorities but was able to secure the volunteer services of teachers to work with young people in New York. By 1910, he was able to report teachers actively attempting to help boys and girls to discover what they could do best and how to secure a job in which their abilities could be used to the fullest advantage (Brewer, 1942; Rockwell, 1958).

Counselors in the school systems of Boston and New York during the 1920s were expected to assist students in making educational and vocational choices. It was during the 1920s that the certification of school counselors began in these two cities. It was also during that decade that the Strong Vocational Interest Inventory was first published (1928) and used by counselors, setting the stage for future directions in career counseling (Shertzer & Stone, 1986).

The Creation of the National Vocational Guidance Association

The early pioneers in counseling clearly reflected society's need for workers who were skilled and happy in what they did. A distinct influence in early counseling was the vocational education movement. In 1906, the National Society for the Promotion of Industrial Education (NSPIE) was formed. Advocates of vocational counseling served on its board and later on the board of the Vocational Bureau established by Parsons. Frank Snedden, a vocational educator from Massachusetts, is given credit for suggesting that organizers hold a vocational guidance conference separate from the NSPIE (Brewer, 1942). Such conferences were held in 1911 and 1912.

At a third national conference in 1913, the National Vocational Guidance Association (NVGA) was formed in Grand Rapids, Michigan (Norris, 1954). Frank Leavitt became the first president and noted the economic, educational, and social demands for guidance and the counseling it entailed. He also felt that vocational guidance was necessary "for the very preservation of society itself" (Norris, 1954, p. 17). Counseling regarding career choice remained an integral part of the movement.

Beginnings of the Mental Health Counseling Movement

The economic, educational, and social reform forces that led to the organization of NVGA also led to other movements, which were later incorporated into the kaleidoscope we call counseling today. In the early 1800s, American reformers such as Dorothea Dix advocated for the establishment of institutions that would treat people with emotional disorders in a humane manner. Although these reformers made great strides in accomplishing their goals, following the Civil War, there was a rapid decline in the conditions related to the humane treatment of institutionalized individuals.

Clifford Beers, who had suffered harsh treatment for mental illness in several psychiatric institutions, published *A Mind That Found Itself*, an autobiography about his experience (Beers, 1908). Publication of this book served as a catalyst for the mental hygiene movement and studies of people with emotional and behavior problems. Early studies of children with emotional problems supported the concept of providing counseling for all children in schools. Beginning at about the same time as vocational guidance, the mental hygiene movement and the field of psychology have had equally strong influences on the development of professional counseling.

In 1908, the same year Frank Parsons opened the Vocational Bureau, William Healy, a physician, established the first community psychiatric clinic. The Juvenile Psychopathic Institute was founded to provide services to young people in Chicago who were having problems. The institute used testing, modified psychoanalysis, and involvement of family members. In 1909, leaders of Cook County, Illinois, deciding that counseling services would benefit children, established countywide child guidance clinics. During the same year, U.S. Congress founded the National Committee on Mental Hygiene.

Early Psychologists

Many credit Wilhelm Wundt with establishing, in the late 1870s in Germany, the first experimental psychology laboratory. One way that Wundt endeavored to study the structure of the mind was by using a form of introspection in which he asked subjects to use self-reflection and verbalize what they were experiencing (Belkin, 1988).

In the United States, William James modified Wundt's approach and tried to discover the functions of the mind, rather than focusing primarily on its structure. James believed

that individuals function as holistic beings who use thoughts, reasoning, emotions, and behaviors. James and his followers are referred to as "functionalists," and they developed experimental designs to facilitate understanding of why human beings' minds function as they do (Belkin, 1988). James' interest in the ideas of "adaptive functioning," "free will," and the conscious functioning of individuals is clearly pertinent to the development of the counseling profession.

A scientific approach to social problems had become popular in the late nineteenth and early twentieth centuries. Granville Stanley Hall founded what many consider the first psychology laboratory in the United States in 1883 at Johns Hopkins University, where he focused on collecting data on the mental characteristics of children (Belkin, 1988). His study of the development of children's mental and physical abilities continued under his tenure as president of Clark University, where he emphasized graduate study and research. Theorists based the scientific approach to social problems on the assumption that they could discover the answer to a social problem through objective research. Even though Hall's work itself has not endured, in addition to founding one of the first psychology departments, Hall was also the primary person to organize the American Psychological Association (APA), and he bestowed the first doctorates in the field of psychology. Of course, the early behaviorists, such as John Watson and B. F. Skinner, and experimental psychologists, such as Max Wertheimer and Wolfgang Kohler, are also associated with the development of the field of psychology.

David Spence Hill, who organized the first guidance and counseling services in New Orleans, was a graduate of Clark University during the presidency of G. Stanley Hall. As director of research for the New Orleans schools, he discovered a need for guidance while researching whether there was a need for a vocational school in his district (Rockwell, 1958). He concluded that there was a need for such a high school, and he also believed it necessary to assist youth in assessing their abilities and in learning about the opportunities that would best help them use those skills. He was aware of Binet's appraisal work and attempted to use the Binet tasks in helping the students in the New Orleans schools. He realized the need for counseling because of his belief that the education of an individual must be of the highest order. Counseling based on scientific research would help secure the best education for each pupil.

If counselors were to help youth know themselves and match their characteristics with qualifications for jobs, some means of measuring individual characteristics was necessary. Counselors relied a great deal on questioning youth about their abilities and their desires, with the implicit assumption that counselees know themselves and can reason about their reported skills and their qualifications for jobs. A counselor's task was to help them in this process by using greater maturity and objective judgment. The development of tests and appraisal instruments lent a scientific air to the process.

In 1905, the Binet–Simon Test was introduced in France. In 1916, L. M. Terman of Stanford University released a revised version of the Binet–Simon Test he had developed, titled the Stanford–Binet Test. With the release of the Stanford–Binet Test, the term *intelligence quotient* or *IQ* was first used. Although the development of the Stanford–Binet Test certainly helped spearhead the testing movement in the United States, it was World War I that truly gave flight to the development and use of standardized instruments.

Influences of World War I and the Development of Testing

World War I influenced the counseling profession's roots in both the vocational guidance and mental health arenas. To screen personnel, the Army commissioned the development

of psychological instruments, including the Army Alpha and Beta IQ tests of intelligence. In the period following World War I, the number and variety of such instruments proliferated, and even though counselors were not the major creators of the instruments, they began to use standardized instruments as tools for use in military, educational, and clinical settings. These screening tools also supported the development of aptitude and interest tests used by counselors in business and educational settings (Aubrey, 1982). Quantifying a person's intelligence, aptitude, achievement, interest, and personality gave a great deal of credibility to a counselor's judgment about the person (Ginzberg, 1971).

After World War I, psychological testing became pervasive in industrial personnel classification, in education, and in counseling offices. Knowledge about and skill in using standardized tests became part of the education of a counselor. Data derived from appraisal instruments were used to make better judgments about counselees and to advise them on what decision was the wisest to make. Large commercial producers of psychometric devices emerged. The process of developing and marketing tests to industry, education, government, and counselors in private practice became quite sophisticated. Counselors were expected to be experts in selecting and using appropriate instruments from a myriad of those offered. Their use in the counseling process became such that testing and counseling were often considered synonymous.

The practice of using tests in counseling was not without controversy. The American Psychological Association did not publish criteria for psychometric instruments used in decision-making until 1954, with the publication of the American Psychological Association's *Technical Recommendations for Psychological Tests and Diagnostic Techniques* (Stephens, 1954). *The Educational Decision-Makers* (Cicourel & Kitsuse, 1963) and *The Brain Watchers* (Gross, 1962) are two examples of many early voices questioning counselors and others' reliance on test data.

Beginnings of Professional Identity

The Great Depression and the Continuation of the Career Guidance Movement

There was continued progress in the development of career counseling during the 1930s. The Great Depression, with its loss of employment for millions of people, demonstrated the need for career counseling to assist adults as well as youth in identifying, developing, and learning to market new vocational skills (Ohlsen, 1983). At the University of Minnesota, E. G. Williamson and colleagues modified the work of Frank Parsons and employed it in their work with students. This is considered by some to be the first theory of career counseling, and it emphasized a directive, counselor-centered approach known as the "Minnesota point of view." Williamson's approach continued to emphasize matching individuals' traits with those of various jobs, and dominated counseling during most of the 1930s and 1940s. The publication of the *Dictionary of Occupational Titles* in 1938 provided counselors with a basic resource to match people with occupations for which they were theoretically well suited (Shertzer & Stone, 1986).

The concept that society would be better if individuals and their occupations were matched for greater efficiency and satisfaction continued to shape the vocational guidance movement. There were a plethora of organizations dedicated to this end. In 1934, members from a number of these organizations, including the American College Personnel Association, the National Association of Deans of Women, the National Federation of Bureau of Occupations, the National Vocational Guidance Association, the Personnel Research Foundation, and the Teachers' College Personnel Association, met to form the

American Council of Guidance and Personnel Associations, or ACGPA (Brewer, 1942, p. 152), By 1939, the leaders had changed the name to the Council of Guidance and Personnel Associations (CGPA), and added other groups: the Alliance for the Guidance of Rural Youth, the International Association of Altrusa Clubs, the National Federation of Business and Professional Women's Clubs, the Western Personnel Service, the American Association of Collegiate Registrars (withdrew in 1941), the Institute of Women's Professional Relations, the Kiwanis International, and the Association of YMCA Secretaries met with the group from time to time.

Brewer (1942) stated that the October 1938 issue of *Occupations*, the publication of the NVGA, listed 96 organizations interested in furthering vocational guidance among the young people of the nation. Counseling per se was coming to the forefront of concerns within the vocational guidance movement. All groups seemed dedicated to placing "square pegs in square holes" through the use of tests.

During the 1950s, the U.S. government was particularly interested in issues related to vocational guidance or career guidance. In response to the Soviet Union's successful space program (for example, the launching of *Sputnik*), the government became concerned with identifying young people with scientific and mathematical talent. To this end, they passed the National Defense Education Act (NDEA) in 1958. Some contend that the impact of NDEA goes well beyond funding of vocational guidance programs. Hoyt stated that NDEA "had a greater impact on counselor education than any other single force" (1974, p. 504). NDEA funded the training of guidance counselors at both the elementary and secondary levels, and NDEA training programs were established to produce counselors qualified for public schools (Herr, 1985). Although the legislation established counselor education programs specifically to train professionals to identify bright children and steer them into technical fields, these counselors were also trained in other domains of counseling as well.

Influence of World War II

World War II strongly influenced the confluence of the vocational guidance and mental health movements, along with that of rehabilitation counseling. The U.S. government continued to rely on standardized instruments and classification systems during this time. It requested that psychologists and counselors should aid in selecting and training specialists for the military and industry (Ohlsen, 1983). Before and during World War II, millions of men and women were tested and assigned to particular duties according to their test scores and their requests. The armed forces stationed counselors and psychologists at many induction and separation centers. Picchioni and Bonk (1983) quoted Mitchell Dreese, of the adjutant general's office, as saying that counseling "is essentially the same whether it be in the home, the church, the school, industry, business or the Army" (p. 54). The process was certainly an extensive use of the scientific approach to counseling. Society, through its representatives in government, had become embroiled in what counseling should be and what it should become. Society has not relinquished that sense of involvement through all the forms, shapes, and colors of the kaleidoscope counseling has become.

The use of standardized tests is not the only reason World War II had a tremendous influence on the counseling profession. Personnel were also needed on the front lines and in aid stations to help soldiers deal with "battle neuroses." Meeting this need was accomplished through minimum training and what seemed to be an "overnight" credentialing of new medical school graduates and research-oriented clinical psychologists.

Even though minimally trained, their interventions resulted in a significant reduction of chronic battle neuroses (Cummings, 1990).

SIDEBAR 1.1 Counselors Dealing with Trauma: The Need for Self-Awareness

All counselors will be called upon to help clients deal with trauma of some kind. When you consider your area of specialization (e.g., counseling in addictions, college, clinical mental health, rehabilitation, or school settings) where do you anticipate you might be confronted with issues of trauma? Write these down and consider the following questions:

- What areas or types of trauma might be especially challenging for you to encounter?
- How might your life experiences impact you as a developing counseling professional?
- What are some ways you can proactively begin to deal with these challenges?

In 1944, the War Department established the Army Separation-Classification and Counseling Program in response to the emotional and vocational needs of returning soldiers. The Veterans Administration (VA) also established counseling centers within their hospitals (Shertzer & Stone, 1986). The VA coined the term *counseling psychology* and established counseling psychology positions and training programs to fill these positions. The National Institute of Mental Health (NIMH) was founded just after World War II and established a series of training stipends for graduate programs in professional psychology. By setting up Ph.D. training stipends, the NIMH reinforced the VA's standard of the doctorate being the entry level into professional psychology. The American Psychological Association (APA) was asked to set standards of training for the new programs in university graduate schools. Although the goal of the VA and NIMH was to train counseling psychologists for the public sector, more and more trained psychologists chose to enter private practice.

During the 1940s a trend toward working with the psychological problems of "normal people" emerged. In reaction to the Nazi movement and World War II, humanistic psychologists and psychiatrists came from Europe to the United States. Their work gradually influenced the strong quantitative leanings in counseling and contributed to the work of well-known psychologists such as Rollo May, Abraham Maslow, and Carl Rogers.

Carl Rogers and the Continuation of the Mental Health Movement

In reviewing a history of what has happened, it is often difficult to know whether events have shaped a leader of an era or whether a person has influenced events. There seems little doubt that Carl R. Rogers, his ideas, and his disciples affected counseling from its core outward. Rogers' idea was that individuals had the capacity to explore themselves and to make decisions without an authoritative judgment from a counselor. He saw little need to make diagnoses of client problems or to provide information or direction to those

he called *clients*. He emphasized the importance of the relationship between the counselor and client. In his system, the client rather than the counselor was the most important factor. Because there was no persuasion used or advice given to follow a particular course, Rogers' system became known as *nondirective counseling*. Rogers became interested in the process of counseling and pioneered the electronic recording and filming of counseling sessions, an unheard-of idea at that time. Working in the academic environment of Ohio State University and the University of Chicago, Rogers published his ideas in *Counseling and Psychotherapy: Newer Concepts in Practice* in 1942 and *Client-Centered Therapy* in 1951.

It is not the purpose of this chapter to delineate all the postulates of what became known as *client-centered counseling* and, later, *person-centered counseling*. It is important to note, however, that the impact this approach had on counseling has continued to the present day. The rise to prominence of Carl Rogers' theory was the first major challenge to the tenets of the Minnesota point of view. In fact, many programs at counseling conventions debated the issue of client-centered versus trait-factored counseling.

Rogers himself remained within the scientific approach to counseling. His concern was to learn what went on in the counseling process, to learn what worked (for him), and what did not. His was a search for necessary and sufficient conditions under which effective counseling could take place. Whenever Rogers reported research about client-centered counseling, it was supported by psychometric data. Certainly one of the effects of Rogers on the profession was to emphasize understanding the counseling process and the need for research. The ensuing debates about the primacy of feeling or rationality as a proper basis of counseling stimulated professional counselors to research their processes and techniques. Scholars refined theories and researchers developed new instruments for determining their efficacy. Counselors in training became as familiar with recording devices as they were with textbooks.

Aubrey (1982) noted that "without doubt, the most profound influence in changing the course and direction of the entire guidance movement in the mid and late 1940s was Carl Rogers" (p. 202). Rogers built on the humanistic and individualistic foundations of the educational guidance movement in which he was trained at Columbia University by formulating the nondirective client-centered approach to counseling. He brought a psychologically oriented counseling theory into the guidance movement, thus, grounding the counseling profession in the broad disciplines of education and psychology (Weikel & Palmo, 1989).

SIDEBAR 1.2 Case Study: Identifying Significant Pioneers in the Counseling Profession

We highlighted several pioneers, such as Frank Parsons, Clifford Beers, Jesse Davis, and Carl Rogers, who have influenced the profession of counseling. Marcus, Jessica, and Emilio are in a learning team in their introduction to counseling class. The teams were asked to identify the pioneers members thought were most important to the profession of counseling, to articulate reasons for their selection, and to try to come to a consensus as to the top two pioneers. Marcus and Jessica are specializing in school counseling and Emilio in clinical mental health counseling. Jessica states that she believes Clifford Beers was the most important as he "began the mental hygiene movement." Marcus believes that Jesse Davis was most influential and Emilio

identifies Carl Rogers as being the most instrumental person in the development of counseling as we know it today. What reasons would you give for each of the choices noted? Of the four pioneers, who do you think was most important to the profession of counseling? Why? Is there anyone else you would add to the list?

Federal Legislation and Its Influence on the Counseling Profession

The Great Depression prompted the development of government-sponsored programs that included a counseling component with an emphasis on classification. Both the Civilian Conservation Corps (CCC) and the National Youth Administration (NYA) attempted to help youth find themselves in the occupational scene of the 1930s (Miller, 1971). In 1938, the George-Deen Act had appropriated $14 million for vocational education; also by 1938, the government established Occupational Information and Guidance Services. The federal government became influential in the field of counseling and remains so today.

The following list exemplifies how the federal government has influenced the development of the counseling profession over the years by offering *examples* of governmental actions and legislation. Primary sources of this information include ACA legislative briefing papers available from the ACA Office of Public Policy and Information; Scott Barstow (personal communications, August 25, 2003, May 15, June 15, 2007, and February 24, 2012); Art Terrazas (personal communications, March 25, 2016, May 18, 2016, September 2, 2016, September 20, 2016), and Vacc and Loesch (1994). We do *not* mean for this to be an exhaustive listing of all legislation that has influenced professional counseling and counseling services. Also, the federal government must reauthorize many of these acts (e.g., Rehabilitation Act) on a regular basis. We have noted *only major revisions* to the original bills enacted and which had an impact on counseling services and professional counselors, rather than listing each time Congress reauthorized an act. We also refer readers to the Current Issues and Trends in Counseling section of this chapter for additional information on recent legislative issues.

SIDEBAR 1.3 The Role of Federal Legislation in Recognition of the Counseling Profession and its Specialties

As you read through federal legislation that Congress has enacted over the years, consider the growth that occurred *and* the challenges faced by professional counselors during each of the decades. Many of the acts are specific to areas of counseling specialization (e.g., career counseling, college counseling, mental health counseling, rehabilitation counseling, school counseling). Identify three laws in your specialty area(s) of interest to investigate further. Consider how each of these laws has influenced current practice in the counseling specialization area you chose. How do you think federal legislation has contributed to the recognition of counseling as a profession, as compared with specialties?

1900–1939

1917 *The Smith-Hughes Act* created federal grants to support a nationwide vocational education program.

1933 *The Wagner-Peyser Act* established the U.S. Employment Service.

1936 *The George-Deen Act* continued the support established by the Smith-Hughes Act.

1938 The U.S. Office of Education established the Occupational and Information Guidance Services Bureau that, among other things, conducted research on vocational guidance issues. Its publications stressed the need for school counseling.

1940s

1944 The Veterans Administration established a nationwide network of guidance services to assist veterans. The services included vocational rehabilitation, counseling, training, and advisement.

1944 The U.S. Employment Service was begun under the influence of the War Manpower Commission. The act established 1,500 offices, and employment "counselors" were used.

1946 *The George-Barden Act* provided government support for establishing training programs for counselors. The emphasis was on vocational guidance and it established a precedent for funding of training for counselors.

1946 The National Institute of Mental Health (NIMH) was established and Congress passed the National Mental Health Act in 1946, authorizing funds for research, demonstration, training, and assistance to states in the use of effective methods of prevention, diagnosis, and treatment of people with mental health disorders.

1950s

1954 *The Vocational Rehabilitation Act* (VRA) recognized the needs of people with disabilities. The VRA was a revision of earlier vocational rehabilitation acts and was prompted, in part, by the government's attempts to meet the needs of World War II veterans. It mandated the development of counselors who specialized in assisting persons with disabilities and allocated funds for the training of these counselors.

1955 *The Mental Health Study Act* of 1955 established the Joint Commission on Mental Illness and Health.

1958 As previously noted, the emphasis of the National Defense Education Act (NDEA) was on improving math and science performance in our public schools; highlighting the importance of counseling in the schools as a way to help students explore their abilities, options, and interests about career development. Title V of this act specifically addressed counseling through grants to schools to carry out counseling activities. Title V-D authorized contracts to institutions of higher education to improve the training of counselors in the schools.

1960s

1962 *The Manpower Development Training Act* was enacted. It established guidance services to individuals who were underemployed or economically disadvantaged.

1963 *The Community Mental Health Centers Act*, an outgrowth of the Mental Health Study Act, was passed. The act mandated the creation of more than 2,000 mental health centers and provided direct counseling services to people in the community as well as providing outreach and coordination of other services. The Community Mental Health Centers Act also provided opportunities for counselors to be employed outside of educational settings.

1964 *The Amendment to the National Defense Education Act* of 1958 continued to impact counseling through the addition of counselors in the public schools, especially elementary schools, aimed at reducing the counselor–student ratio.

1965 *The Elementary and Secondary Education Act* (ESEA) did much to develop and expand the role of the elementary school counseling program and the services provided by the elementary school counselor.

1970s–1980s

1972 Title IX of the Education Amendments to the 1964 Civil Rights Act mandated that no one be discriminated against or excluded from participating in any federally funded educational program or activity on the basis of sex. It also prohibited sex-biased appraisal and sex-biased appraisal instruments.

1975 *Public Law (P. L.) 94–142*, also known as the Education for All Handicapped Children Act, mandated that all children, regardless of their disabilities, were entitled to an appropriate free public education. Counselors became instrumental in designing, implementing, and evaluating the individualized education plans, which the law required for each student with special needs. This act is now most commonly referenced as the *Individuals with Disabilities Education Act* or "IDEA."

1976 *P. L. 94–482* was enacted, extending and revising the Vocational Education Act of 1963 and its 1968 amendments. *P. L. 94–482* directed states to develop and implement programs of vocational education specifically to provide equal education opportunities to both sexes and to overcome sex bias and stereotyping. It also specified that funds must be used in vocational education for individuals who were disadvantaged, had limited English proficiency, or had handicapping conditions.

1977 Congress added Sections 503 and 504 to the civil rights law, typically known as the Rehabilitation Act of 1973. Section 503 mandated all employers conducting business with the federal government (meeting specific criteria) to take affirmative action in the recruitment, hiring, advancement, and treatment of qualified persons with disabilities. This act was a precursor to what may be the more widely known *Americans with Disabilities Act*, which the government enacted in 1990.

1977 President Carter established the President's Commission on Mental Health.

1979 *The Veterans' Health Care Amendments* called for the provision of readjustment counseling and related mental health services to Vietnam-era veterans.

1980 *The Mental Health Systems Act* was passed, stressing the need for balancing services in both preventive and remedial mental health programs. The act required the development of new services for children, youth, minority populations, older people, and people with chronic mental illness. Congress repealed the act during the same year in which they passed it because of the severe federal budget cuts for social programs during the first year of President Reagan's term in office.

SIDEBAR 1.4 Balancing Proactive and Reactive Counseling Services: Budget Cuts, Policy, and Advocacy

In this chapter we present information on the impact of some major historical events on the development of the counseling profession. Consider some of the modern-day events that have affected our world and nation in recent years. Which worldwide disasters or crises (natural or created by people) have influenced the profession of counseling? Consider events that have possibly impacted the lives of the clients or students with whom you will work. Do you think the counseling profession is still being shaped by societal events?

After reviewing materials on the ACA website (www.counseling.org/government-affairs/public-policy), as well as in the professional literature, discuss in teams:

(a) how you think federal and state funding and budget cuts have influenced the balance in counseling services that are reactive to crisis and those that are more proactive;
(b) what actions counselors can take to advocate for funding for both prevention and remedial counseling services.

1984 *Carl D. Perkins Vocational Education Act* amended the Vocational Education Act of 1963. Its primary purpose was to help the states develop, expand, and improve vocational education programs. The act sought to include previously underserved people such as those with disabilities, adults in need of both training and retraining, and single parents, to name but a few. The legislation indicated that career guidance and counseling functions should be performed by *professionally trained counselors*. Also, the entire act contained language that indicated how important legislators believed counseling and career development services to be.

1990s

1990 *Americans with Disabilities Act* (ADA) prohibited job discrimination against people with disabilities. It also mandated that individuals with disabilities have the same access to goods, services, facilities, and accommodations afforded to all others.

1990 *Carl D. Perkins Vocational Education Act* was reauthorized, setting directions for state and local agencies to develop vocational and applied education programs. It targeted single parents, displaced homemakers, and single pregnant women, noting that states were to use a certain percentage of their funds to provide basic academic and occupational skills and materials in preparation for vocational education and training to provide these people with marketable skills. In addition, states were required to use funds to promote sex equity by providing programs, services, and comprehensive career guidance, support services, and preparatory services for girls and women.

1994 *The School-to-Work Opportunities Act* set up partnerships among educators, businesses, and employers to facilitate the transition of those students who planned on moving from high school directly to the world of work.

1995 *Elementary School Counseling Demonstration Act* allocated $2 million in grant money for schools to develop comprehensive elementary school counseling programs.

1996 *The Mental Health Insurance Parity Act* (enacted in 1996 and effective from January 1, 1998) prevented health plans that covered mental health services from placing unequal caps on the dollar amount covered (either annually or on a lifetime basis) for the provision of mental health services if these same caps are not placed on the coverage of other medical services. Although this act had several limitations (e.g., it did not require that health plans provide mental health benefits), it was a major step toward parity of insurance coverage for mental health services (ACA Office of Public Policy and Information, 1996).

1996 *Health Insurance Portability and Accountability Act* (HIPAA, Public Law 104–191) included language to promote "administrative simplification" in the administration of health care benefits by establishing national standards for the electronic transmission of health information, for the use and disclosure of personally identifiable health information, and for the security of information. Although the standards do not contain any counselor-specific provisions, they have had an impact on all counselors, both as providers of mental health services and as health care consumers.

1997 *The Balanced Budget Act* included provisions that prohibit Medicaid managed care plans from discrimination against providers on the basis of the type of license they hold. This prohibition did not extend to fee-for-service plans administered through Medicaid.

1998 *Higher Education Act Amendments* reauthorized higher education programs into law for another 5 years. In addition to dropping student loan interest rates and increasing Pell Grant awards, the act created the *Gaining Early Awareness and Readiness for Undergraduate Programs* (GEAR-UP), which provided grants for establishing partnerships between colleges, schools, and community organizations. The provisions included payment for counseling services to certain at-risk and low-income students and other elementary, middle, and secondary school students. In addition to advising and counseling services related to financial aid, and college admissions, the amendments allow for personal counseling, family counseling, and home visits for students with limited English proficiency (ACA Office of Public Policy and Information, 1998a).

1998 *The Health Professions Education Partnerships Act* (HPEPA) is a landmark piece of legislation. It recognized professional counselors under health professional training programs. Specifically, education programs, counseling students and graduates, and counselor educators stood to be made eligible for a wide range of programs operated by the federal Health Resources and Services Administration (HRSA) and the federal Center for Mental Health Service (CMHS) to the same extent as other master's-level mental health professions (e.g., social workers). Where the term "graduate programs in behavioral and mental health practice" was referenced in these programs, the provisions passed in HPEPA included graduate programs in counseling (ACA Office of Public Policy and Information, 1998b).

1998 *The Workforce Investment Act* (WIA) revamped all job training programs in the country and reauthorized the Rehabilitation Act. According to the ACA Office of Public Policy and Information (1998c), the WIA streamlined requirements for the major federal grant programs that support training and related services for adults, dislocated workers, and disadvantaged youth. Under the WIA, all adults, regardless of income or employment status, became eligible for core services such as skills

assessments, job search assistance, and information on educational and employment opportunities.

1998 *Reauthorization of the Rehabilitation Act*. As noted, the WIA reauthorized the Rehabilitation Act for another 5 years. The act included funds for state-administered vocational rehabilitation services for people with disabilities. In addition, the act funded research on rehabilitation and disabilities, training for rehabilitation counselors, independent living centers, advocacy services, and other initiatives that facilitate the employment of individuals with disabilities. The act upheld previous requirements that state agency professionals meet state or national certification or licensure requirements. These requirements meant that professional rehabilitation counselors had to hold a master's degree in rehabilitation counseling or a closely related field. The act extended this requirement to private contractors of state agencies.

1999 *Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act* (Public Law 106–554) included a section requiring the Medicare Payment Advisory Commission (MedPAC) to conduct a study on the appropriateness of establishing Medicare coverage of licensed professional counselors and other non-physician providers, including marriage and family therapists and pastoral counselors. MedPAC issued a weakly written report recommending *against* covering licensed professional counselors, marriage and family therapists, and pastoral counselors in June of 2002. Although MedPAC came to a negative conclusion, this was a critical move forward for the counseling profession. The language in P. L. 106–554 marked the first time that Congress and the president had enacted legislation even *referencing* licensed professional counselors with respect to Medicare.

1999 *The Elementary School Counseling Demonstration Act* was approved as part of the Omnibus Spending Package for FY 2000. The act allocated $20 million for schools to hire *qualified* school counselors. These funds were made available to school districts that are awarded 3-year grants by the Department of Education.

1999 *The Work Incentives Improvement Act* (WIIA) may be considered the most significant federal law enacted for people with disabilities since the Americans with Disabilities Act passed in 1990. The WIIA removed many of the financial disincentives that have prevented millions of people with disabilities from working. For example, it changed out-dated rules that end Medicaid and Medicare coverage when people with disabilities enter or reenter the workplace. In addition, it extended Medicare Part A coverage for people on Social Security disability insurance who return to work for another 4½ years.

2000–2015

2001 *National Defense Authorization Act* (Public Law 106–398) included language requiring the Office of the Civilian Health and Medical Program of the Uniformed Services (known as TRICARE) Management Authority to conduct a demonstration project allowing mental health counselors to practice independently, without physician referral and supervision. In 2001, licensed professional counselors were the only nationally recognized mental health professionals required by TRICARE to operate under physician referral and supervision.

2001 *No Child Left Behind Act* (NCLB, Public Law 107–110) was a massive re-authorization of the federal education programs contained in the Elementary and Secondary Education Act and included language renaming the Elementary School Counseling Demonstration Program the Elementary and Secondary School Counseling

Program (ESSCP). This language both removed the "demonstration" tag from the program and expanded it to secondary schools. Under the NCLB language, it was mandated that the first $40 million appropriated for the program in any year must be devoted to supporting counseling programs and services in elementary schools.

2006 *The Veterans Benefits, Healthcare, and Information Technology Act* (Public Law 109–461) included language establishing explicit recognition of licensed mental health counselors as health care professionals within the Department of Veterans Affairs (VA) health care programs. In addition to allowing the hiring of licensed professional counselors in clinical and supervisory positions with VA health care facilities, the ACA advocated for this provision as an avenue to the development of a position description for counselors by the Federal Office of Personnel Management, which would be applicable to all federal agencies.

2008 The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (included in Division C of Public Law 110–343) prohibited health insurance plans from placing financial requirements or treatment limitations on the use of mental health or substance use disorder benefits that are not also used for substantially all other medical/surgical benefits. The goal of the law was to end the inequities in insurance coverage for the treatment of behavioral disorders, although insurance companies are allowed to continue to use standard care management practices such as utilization review and the use of medical necessity criteria. The law exempts policies covering fewer than 50 employees.

2010 The *Patient Protection and Affordable Care Act* (Public Law 111–148, as amended by Public Law 111–152) established, for the first time, a functioning health insurance system for the U.S., based on employer-provided private health insurance for Americans who are in the workforce combined with public health insurance coverage and supports for those without affordable private sector coverage. Importantly for counselors, the legislation required health insurance plans to cover mental and addictive disorder services—and to do so meeting the requirements of the Mental Health Parity and Addiction Equity Act. Also, the law contained a provision prohibiting health plans from discriminating against providers based on their type of license. The major coverage expansion provisions of the law, including the operation of state health insurance exchanges, took effect in 2014, as did the provider nondiscrimination provision.

2013 The *Workforce Investment Act* (WIA) was reauthorized and, in addition to job training programs, included core services through employment services, adult education, and family literacy programs.

2015 The *National Defense Authorization Act* was reauthorized. As previously noted, in 2001, the TRICARE Management Authority was mandated to conduct a demonstration project allowing mental health counselors to practice independently, without physician referral and supervision. The 2015 reauthorization of the National Defense Authorization Act included an amendment making that a reality. The provision, as signed into law, allows for all licensed professional counselors (LPCs) who "received their counseling degree from regionally accredited programs in counseling to become independent practitioners under TRICARE until 2021" (ACA, 2015a, para. 8). The amendment represents several years of advocacy by the ACA and professional counselors across the country. In addition to opening job opportunities for LPCs, it broadens access to mental healthcare services to the more than 4.8 million TRICARE beneficiaries.

2015 President Obama signed the *Every Student Succeeds Act (ESSA)* into law in December. The ESSA reauthorizes the Elementary and Secondary Education Act (ESEA), last reauthorized in 2002 as the *No Child Left Behind Act* and shifts decision-making authority regarding how to serve students, especially disadvantaged students, from the federal government to the states. Also, the Elementary and Secondary School Counseling Program (ESSCP), "a program conceived by ACA more than thirty years ago and funded by Congress for $49 million last year will now be part of a block grant provided to the states" (ACA, 2015b, para 4). This shift to block grants bodes well for the funding of school counseling services because as "states must allocate at least twenty percent of their block grant to programs that include the ESSCP, our hope is that school districts may actually be allocated with even more funds than in previous years" (Todd, as cited in ACA, 2015b).

Continuing Development of Professional Identity

History of the American Counseling Association

The mission of the American Counseling Association is "to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity" (www.counseling.org/about-us/about-aca). Table 1.1 shows the divisional structure of ACA as of July 2016 along with the year in which each division was first established. It is beyond the scope of this chapter to provide a detailed description of each of the divisions, and we strongly encourage students to review the information on all of the divisions on the ACA website (www.counseling.org/about-us/divisions-regions-and-branches/divisions).

Vacc and Loesch (1994) noted that one way to understand the evolution of a profession is to study the history of a representative professional organization. The ACA has a rich history that exemplifies its representation of professional counselors. One can see the philosophical development of the counseling profession by reviewing the three names by which ACA has been known, along with the times those name changes occurred. From its founding in 1952 until 1983, ACA was known as the American Personnel and Guidance Association (APGA). From 1983 until 1992, it was called the American Association for Counseling and Development (AACD). In 1992, the governing body of the association renamed it the American Counseling Association. For purposes of simplicity, the association will be referred to as ACA regardless of the time reference.

Although most note its official inception as 1952, the ACA can trace its organizational beginnings to the turn of the twentieth century with the formation of one of its founding divisions, then the National Vocational Guidance Association. Its roots in vocational guidance, education, and psychology have made for an interesting, rich, and often rocky evolution of counseling as a profession unto itself, even before the founding of the ACA. The NVGA leadership had considered changing its name at least five times between 1922 and 1948 to reflect better the concern members had about the total adjustment of their clients (Norris, 1954).

Members of the American Council of Guidance and Personnel Associations (ACGPA), a federation of associations, were also considering whether it was wise or efficient to attempt to belong to several organizations doing essentially the same thing. Groups belonging to the federation had the practice of meeting in conventions at the same time and place.

Table 1.1 Divisions of the American Counseling Association as of August 2016

AADA	Association for Adult Development and Aging (founded in 1986).
AARC	Association for Assessment and Research in Counseling (originally the Association for Measurement and Evaluation in Guidance, AMEG then Association for Assessment in Counseling and Education, AACE; AARC was founded in 1965).
ACAC	Association for Child and Adolescent Counseling (organizational affiliate founded in 2010, achieved division status in 2013).
ACC	Association for Creativity in Counseling (founded in 2004).
ACCA	American College Counseling Association (founded in 1991).
ACES	Association for Counselor Education and Supervision (founded in 1938; one of the founding organizations of ACA; formerly the National Association of Guidance and Counselor Trainers).
AHC	The Association for Humanistic Counseling (founded in 1931; one of the founding organizations of ACA; formerly the Student Personnel Association for Teacher Education [SPATE], Association for Humanistic Education and Development, and Counseling Association for Humanistic Education and Development).
ALGBTIC	Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling (founded in 1996 as the Association of Gay, Lesbian, and Bisexual Issues in Counseling).
AMCD	Association for Multicultural Counseling and Development (founded in 1972 as the Association of Non-White Concerns in Personnel and Guidance).
AMHCA	American Mental Health Counselors Association (founded in 1978).
ARCA	American Rehabilitation Counseling Association (founded in 1958 as the Division of Rehabilitation Counseling).
ASCA	American School Counselor Association (founded in 1953).
ASERVIC	Association for Spiritual, Ethical, and Religious Values in Counseling (founded in 1974 as the National Catholic Guidance Conference).
ASGW	Association for Specialists in Group Work (founded in 1973).
CSJ	Counselors for Social Justice (founded in 1999).
IAAOC	International Association of Addictions and Offender Counselors (founded in 1972 as the Public Offender Counselor Association).
IAMFC	International Association of Marriage and Family Counselors (founded in 1989).
MGCA	Military and Government Counseling Association (founded in 1984; formerly the Military Educators and Counselors Association, then Association for Counselors and Educators in Government [ACEG]).
NCDA	National Career Development Association (founded in 1913 and was one of the founding ACA organizations; formerly the National Vocational Guidance Association).
NECA	National Employment Counseling Association (founded in 1966; formerly the National Employment Counselors Association [NECA]).

By the late 1940s, groups had established their identities in work settings, and members had begun to see commonalities of purpose and function. The name of the federation had changed from ACGPA to the Council of Guidance and Personnel Associations (CGPA) in 1939, so there was a precedent for a name change.

In 1948 Daniel Feder, as chair of CGPA and president of NVGA, urged the forming of a national organization to include individuals as well as associations. A committee on unification was appointed to develop a plan for such an organization. Its plan was presented at the 1950 convention and forwarded to the organizations concerned

Table 1.2 Organizational Chronology of the American Counseling Association

Year	*Division Name*	*Event*
1951	PGA	The Personnel and Guidance Association was formed.
1952	APGA	American Personnel and Guidance Association became the new name for PGA.
1952	APGA	The following divisions became founding partners of APGA. ACPA (American College Personnel Association) NVGA (National Vocational Guidance Association) SPATE (Student Personnel Association for Teacher Education) NAGCT (National Association of Guidance and Counselor Trainers)
The following divisions became part of ACA or changed their names:		
1953	ASCA	American School Counselor Association became a division.
1957	DRC	ACA added the Division of Rehabilitation Counseling.
1961	ACES	Association for Counselor Education and Supervision replaced the former NAGCT.
1962	ARCA	American Rehabilitation Counseling Association became the new name for the former DRC.
1965	AMEG	Association for Measurement and Evaluation in Guidance was established.
1966	NECA	National Employment Counselors Association became a division.
1972	ANWC	Association for Non-White Concerns in Personnel and Guidance was formed.
	POCA	Public Offender Counselor Association was established.
1973	ASGW	Association for Specialists in Group Work was established.
1974	NCGC	National Catholic Guidance Conference became a division.
1975	AHEAD	Association for Humanistic Education and Development replaced the former SPATE.
1977	ARVIC	Association for Religious Values in Counseling replaced what had been known as NCGC.
1978	AMHCA	American Mental Health Counselors Association became a division.
1983	AACD	American Association for Counseling and Development became the new name for what had been called APGA.
1984	AMECD	Association for Measurement and Evaluation in Counseling and Development became the new name for the former AMEG.
	NCDA	National Career Development Association became the new name of the former NVGA.
	AMCD	Association for Multicultural Counseling and Development replaced the former Association for Non-White Concerns in Personnel and Guidance.
	MECA	Military Educators and Counselors Association became an organization affiliate of AACD.
1986	AADA	Association for Adult Development and Aging was formed.
1989	IAMFC	International Association of Marriage and Family Counselors was established.
1990	IAAOC	International Association of Addictions and Offender Counselors replaced the former POCA.
1991	ACCA	American College Counseling Association was formed to replace ACPA, which was in the process of withdrawing from ACA.
1992	ACPA	American College Personnel Association disaffiliated from ACA.
	AAC	Association for Assessment in Counseling became the new name for AMECD.
	ACA	American Counseling Association, formerly APGA.

1993	ASERVIC	Association for Spiritual, Ethical and Religious Values in Counseling became the new name for ARVIC.
1995	ACEG	Association for Counselors and Educators in Government became the new name for MECA.
1996	AGLBIC	Association of Gay, Lesbian, and Bisexual Issues in Counseling became an organizational affiliate.
1997	AGLBIC	AGLBIC achieved division status.
1998	ACEG	ACEG became a division.
1999	CSJ	Counselors for Social Justice became an organizational affiliate.
	C-AHEAD	AHEAD changed its name to the Counseling Association for Humanistic Education and Development.
2002	CSJ	CSJ became a division.
2003	AACE	AAC changed its name to the Association for Assessment in Counseling and Education.
2004	ACC	Association for Creativity in Counseling became a division.
2007	ALGBTIC	AGLBIC voted to change its name to the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling.
2010	AHC	Counseling Association for Humanistic Education and Development changed its name to the Association for Humanistic Counseling.
	ACAC	Association for Child and Adolescent Counseling became ACA's newest organizational affiliate.
2013	ACAC	Association for Child and Adolescent Counseling became the twentieth division of ACA.

(McDaniels, 1964). Both the NVGA and the American College Personnel Association approved the plan and arranged their constitutions to join the new organization as divisions in 1951. At this time the Personnel and Guidance Association (PGA) was born. The following year, 1952, PGA changed its name to the American Personnel and Guidance Association (APGA) to avoid confusion with the Professional Golfers Association (PGA). APGA is now known as the American Counseling Association (ACA). Table 1.2 presents highlights of the ACA's development since its founding.

Professionalism: A Developmental Perspective

A review of Table 1.2 indicates not only the developmental nature of the ACA but also the evolving diversity of its divisions and its membership. The concept of unification was a common theme in this country in the 1950s (Vacc & Loesch, 1994). This trend may have influenced the four independent founding organizations: NVGA (now the National Career Development Association, NCDA), American College Personnel Association (replaced as an ACA division now by the American College Counseling Association), the National Association of Guidance and Counselor Trainers (NAGCT, now the Association for Counselor Education and Supervision or ACES), and SPATE (now AHC; the Association for Humanistic Counseling) to come together to work as one federation. The basic format of autonomous divisions working within an umbrella organization has continued to the present time. ACA has added divisions as members' interests or counselor work settings changed because of shifts in the socioeconomic milieu.

Change is very much reflected in the chronological evolution of ACA. For example, the parent organization, APGA, changed its name twice over a 40-year period. Before 1983, APGA began to feel pressures from its membership for a name change that would

accurately reflect the purposes and work activities of its members. The terms *guidance* and *personnel* were onerous to some members. In addition to describing the profession better, the term *counseling* was more prestigious and better understood by the public. By 1983, several of the divisions already recognized the terms *counseling* or *counselor* in their titles (ASCA, ARCA, ACES, ARVIC, POCA, NECA, and AMHCA). To appease its growing and diverse membership, to have a clearer identity with counseling, and to attract new members in a changing society, APGA became the American Association for Counseling and Development (AACD). Nine years later in 1992, the name was again changed to the American Counseling Association, removing the word *development* from its title.

Beginning in 1952 with four divisions, the first new division to join the parent organization was the American School Counselor Association (ASCA) in 1953, which quickly became one of the two largest ACA divisions. After World War II, there was a growing recognition in America that people with disabilities had counseling needs. At the same time that the Veterans Administration was attempting to meet the needs of returning World War II servicemen and women, some ACA members were becoming involved in rehabilitation counseling. These factors resulted in the organization of the second new division to join ACA, the American Rehabilitation Counseling Association (ARCA) in 1957 (known as the Division of Rehabilitation Counseling from 1957 to 1962). From that time until the present, divisions were created and revised to reflect changes in society and to meet the professional needs of ACA members. Following are just a few examples. We hope you find that Tables 1.1 and 1.2 are helpful in keeping track of all the acronyms and changes in the ACA and its divisions.

- During the 1960s and early 1970s, there was increasing concern about minority representation with the structure of ACA. That concern, along with the general social consciousness movement in the 1960s and early 1970s, prompted the development of an interest-based division then entitled the Association for Non-White Concerns in Personnel and Guidance (ANWC), which was added in 1972 and is now referred to as the Association for Multicultural Counseling and Development (AMCD).
- The formation of the Public Offender Counselor Association (POCA) in 1974 brought into the organization people involved with an increasing juvenile and probation population and those who worked with or within our prison systems. During the 1980s, the correlation between addictive and criminal behaviors became quite clear. Many POCA members became interested in broadening the focus of POCA, and it became the International Association of Addictions and Offenders Counselors (IAAOC) in 1990.
- The founding of the Association of Gay, Lesbian, and Bisexual Issues in Counseling (AGLBIC; which later became the Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling) as an organizational affiliate in 1996 and a division in 1997, demonstrated the recognition of the growing numbers of counselors who serve clients dealing with issues associated with their sexual orientation. AGLBIC leaders changed the name to the Association for Lesbian, Gay, Bisexual and Transgender Issues in Counseling in 2007.
- ACA members formed the Counselors for Social Justice (CSJ) as an organizational affiliate in 1999 to address issues related to social justice, oppression, and human rights within the counseling profession and the community at large. CSJ became an ACA division in 2002.

It is important to understand that the American Counseling Association is more than a collection of divisions. There is also a geographical regional structure: (1) North Atlantic (Connecticut, Delaware, the District of Columbia, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and the Virgin Islands); (2) Southern (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, and West Virginia); (3) Midwest (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, and Wisconsin); and (4) Western (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming). Each region, representing ACA state branches, was established to provide leadership training, professional development, and continuing education of branch members following the strategic plan adopted by the ACA.

The ACA provides its membership with a plethora of books, scholarly journals, and monographs on topics of interest to counselors. Its workshop, podcasts, webinars, online courses, and regional and national conventions provide intensive training opportunities that keep members up to date and provide the continuing education units necessary to maintain licensure or certification. Its *Code of Ethics* (ACA, 2014) provides members and the public with both professional direction and guidance. Its legislative and government affairs staff and committee not only alert members to current legislation that is either helpful or harmful to counseling and consumers of counseling services but also gives members a voice in policy development at the federal, state, and local levels.

SIDEBAR 1.5 Belonging to Professional Associations: Are there Benefits or Just Costs?

Carefully explore ACA's website and take note of the resources available to students and professionals. Start to gather more information about specific divisions and interest networks that interest you (www.counseling.org/AboutUs/DivisionsBranchesAndRegions/TP/Divisions/CT2.aspx and www.counseling.org/aca-community/aca-groups/interest-networks). Ask your professors, supervisors, and advisors about their professional involvement. What do you think are the benefits of professional membership in ACA and its divisions? Which divisions appeal the most to you and why? How do you feel these divisions could serve you professionally? Consider how you might become involved as a student.

Credentialing and the "Professionalization" of Counseling

The most commonly noted criteria used to evaluate whether an occupation has evolved to the status of a profession include (1) a specialized body of knowledge and theory-driven research, (2) the establishment of a professional society or association, (3) control of training programs, (4) a code of ethics to guide professional behavior, and (5) standards for admitting and policing practitioners (Caplow, 1966). Given these criteria, no historical perspective of the counseling profession can be considered complete without a discussion of the development of standards related to the preparation and practice of professional counselors.

The counseling profession has met the majority of conditions just noted. There is an evolving body of knowledge and systematic theories and a body of literature to provide

a forum for such information. ACA serves as the primary professional association for counselors. There are standards for training programs, professional preparation, and ethical behavior (see Chapter 3). The profession has not only established accredited counselor-training programs, but now grants credentials to individuals demonstrating professional competencies and has established some form of licensure or certification for professional counselors in all states, legally validating the profession.

SIDEBAR 1.6 Case Study: Understanding Counseling as a Profession

Alma is a graduate student in the first semester of her master's counseling program. At a family gathering, Alma's cousin Hector asks why she needs a master's degree to learn how to listen to people. He explains his belief that being a counselor is basically the same thing as being a good friend. You just have to listen to people and give good advice. He tells Alma that she is already good at those things and does not understand why she cannot just start her private counseling practice now. After all, she already went to college and was even a "peer counselor" in her residence hall!

Explain how Alma could respond to her cousin about the profession of counseling. How is counseling different from "being a good friend?" What about if someone asked you how counseling is the same as or different from psychology or social work? Have you encountered similar situations or questions from friends or family members? How did you respond? How might you respond differently after reading this chapter?

The term *credentialing* was created to represent a broad array of activities pertaining to the establishment of professional training standards and regulations for practice (Bradley, 1991) such as accreditation of academic programs, national board certification, and state licensure. Following is an overview of each of these areas as related to the counseling profession.

Accreditation

Accreditation is one means of providing accountability. The licensed professions in this country began the process of regulation and quality control by developing standards for training programs. Also, institutions and educational programs seek accredited status as a way to demonstrate their academic quality to students and the public and for their students to become eligible for federal funds. According to the Council for Higher Education Accreditation (CHEA, 2002),

> Accreditation is review of the quality of higher education institutions and programs. In the United States, accreditation is a major way that students, families, government officials, and the press know that an institution or program provides a quality education [. . .] Accreditation is a process of external quality review used by higher education to scrutinize colleges, universities, and educational

> programs for quality assurance and quality improvement. . . . In the U.S., accreditation is carried out by private, nonprofit organizations designed for this purpose.

The development of standards of preparation for counselors began approximately 56 years ago when a joint committee of the ACES and ASCA, divisions of the ACA, began two major studies in 1960. More than 700 counselor educators and supervisors and 2,500 practicing counselors participated in the studies over a 5-year period (Altekruse & Wittmer, 1991). The results facilitated the creation of the "Standards for Counselor Education in the Preparation of Secondary School Counselors," the first set of standards sanctioned for counselor education, in 1964. After a 3-year trial, they were officially adopted by ACES in 1967 (Association for Counselor Education and Supervision, 1967). Shortly after that, "Standards for Preparation of Elementary School Counselors" (APGA, 1968) and "Guidelines for Graduate Programs in the Preparation of Student Personnel Workers in Higher Education" (APGA, 1969) were established.

The Council on Rehabilitation Education (CORE), incorporated as a specialized accrediting body with a focus on rehabilitation counseling in 1972, was a forerunner in setting educational standards and graduate program accreditation in counseling (Sweeney, 1991). The leaders responsible for the creation of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) used CORE as a model. Both councils require similar generic counseling curricula (not focused on specialties) and standards. Also, CORE focuses on rehabilitation counselor education (RCE) curricula while CACREP addresses program area curricula and standards in other specialty areas but does not include specific RCE curricula.

Council on Rehabilitation Education (CORE)

ARCA and the following four professional organizations had representatives on the first CORE board of directors: Council of Rehabilitation Educators (now the National Council on Rehabilitation Education, NCRE), Council of State Administrators of Vocational Rehabilitation (CSAVR), International Association of Rehabilitation Facilities (now American Rehabilitation Association, ARA), and the National Rehabilitation Counseling Association (NRCA). CORE's current membership has two public members, the chair of the Commission on Standards and Accreditation, and individuals appointed from the following sponsoring organizations: NRCA, ARCA, NCRE, CSAVR, and the National Council of State Agencies for the Blind (NCSAB).

As of July 2016, CORE had accredited 107 master's programs offering a degree in rehabilitation counseling in the United States and Puerto Rico (CORE, 2016). Since its creation, CORE has reviewed and revised the standards for the accreditation of master's programs in rehabilitation counselor education on a regular basis. The first major standards revisions in 1981 were followed by revisions in 1988, 1997, 2004, 2011, and 2014. Readers can review the most recent revisions in the CORE standards on the CORE website (www.core-rehab.org).

According to the 2014 standards, all CORE-accredited programs are expected to address the following 10 curricular areas of study: professional identity and ethical behavior; psychosocial aspects of disability and cultural diversity; human growth and development; employment and career development; counseling approaches and principles; group work and family dynamics; assessment; research and program evaluation; medical, functional, environmental aspects of disability; and rehabilitation services, case management, and

related services (CORE, 2014). CORE required supervised practicum and internship experiences under the 1997, 2004, 2011, and 2014 standards. These experiences are very similar to the current (2016) CACREP standards.

Council for Accreditation of Counseling and Related Educational Programs (CACREP)

According to Altekruse and Wittmer (1991), ACES developed "Standards for Entry Preparation of Counselors and Other Personnel-Service Specialists" in 1973. This document, which merged earlier guidelines, was officially adopted by the ACA governing body in 1979. At that time, ACES was the only association using the standards of training. It was not until 1981 that the ACA's board of directors (governing council) adopted a resolution to formally oversee the responsibilities of the ACES National Committee on Accreditation. The resolution led to the establishment of the Council for Accreditation of Counseling and Related Educational Programs (CACREP), which was formed as an independently incorporated accrediting body, separate from but affiliated with ACA. Since its inception, CACREP has conducted reviews of its accreditation standards. There have been five significant revisions made to the 1981 standards adopted by CACREP, in 1988, 1994, 2001, 2009, and 2016. These revisions are necessary to keep up with the continually evolving field of counseling.

In addition to providing for accreditation of doctoral-level programs in counselor education and supervision, the 2016 CACREP standards (CACREP, 2016) also provided for the accreditation of master's degree programs in the following specialty areas: addictions; career counseling (separate from community counseling); clinical mental health counseling; clinical rehabilitation counseling; college counseling and student affairs; marriage, family, and couple counseling; and school counseling. Under the 2016 standards, CACREP accredits community counseling and mental health counseling programs as clinical mental health counseling, and gerontological counseling programs are no longer separately accredited.

As of April 2016, CACREP had 545 accredited programs at 323 institutions (CACREP, 2016). The majority of the master's programs were in the areas of school counseling (247) and clinical mental health counseling (185). In addition, there were 26 mental health accredited programs (accredited under the 2001 standards), 12 student affairs and college counseling accredited programs, as well as 7 college counseling programs and 13 student affairs programs, 42 accredited marriage and family counseling/therapy programs, 3 accredited addictions programs, and 10 accredited career counseling programs (CACREP, 2016).

All academic programs accredited by CACREP, regardless of specialty designation, share a common core of curricular requirements. According to the 2016 CACREP Accreditation Procedures Standards (CACREP, 2015), *all accredited programs must address the following eight curricular areas*: professional orientation and ethical practice, social and cultural diversity, human growth and development, career development, helping relationships, group work, assessment, and research and program evaluation. Supervised practica and internships also are required across all program areas. As well as these common core areas, CACREP-accredited programs must also offer specific types of curricular experiences related to the program accreditation, such as clinical mental health, school counseling, and student affairs and college counseling.

In addition to shifts in the areas of specialization that are accredited by CACREP, there was a significant shift in the 2016 CACREP standards, from knowledge-based

to outcome, or performance-based standards. Under the current standards, students are required to demonstrate the ability to implement their knowledge in the core and program or concentration areas, and departments are required to document these outcomes. Further, according to the 2016 standards, core counseling program faculty are required to have earned a doctoral degree in counselor education (rather than counseling psychology or other related disciplines) *or* "have related doctoral degrees and have been employed as full-time faculty members in a counselor education program for a minimum of one full academic year before July 1, 2013" (CACREP, 2016, p. 7).

CORE/CACREP Merger

Leaders of CORE and CACREP signed a Plan of Merger Agreement in July of 2015. This historic affiliation was first entered into by CORE and CACREP in 2013 as an agreement after many years "of discussion on strengthening the counseling profession through the establishment of a single unified accreditation process for counselor preparation programs" (CACREP, 2015, para. 1). Beginning July 1, 2017, rehabilitation counselor programs will be accredited through CACREP. This decision was due in part to the recognition of the CACREP name and an effort to strengthen professional counselor identity. As a result of the merger, students participating in rehabilitation counseling programs will be eligible to sit for the National Counselor Examination (NCE), administered by NBCC National Board for Certified Counselors; (CACREP, n.d.). For updates regarding the merger, please go to www.core-rehab.org (see "What's New?") and www.cacrep.org/news-and-events/ (see "CACREP/CORE Updates").

Certification

Certification is one of the most confusing of the credentialing terms (Brown & Srebalus, 1988). People use the term in reference to (1) the process of becoming qualified to practice in public schools, (2) state laws passed in the same ways as licensure laws, and (3) recognition bestowed on individuals by their professional peers (such as certified public accountants). Certification most typically grants recognition of competence by a professional group or governmental unit and allows for the use of certain titles (e.g., National Certified Counselor) but does not confer authority to the holder to practice a profession or restrict others who are not certified from practicing a profession (Forrest & Stone, 1991). An exception to this is that professional counselors holding positions in public schools must be certified by the state to do so.

Types and Purposes of Certification

Certification in Schools

As noted, state boards or departments of education, by authority of state legislatures, establish certification standards for teachers, counselors, administrators, and other school personnel. Certification of school counselors began in Boston and New York in the 1920s, but not until the National Defense Education Act (NDEA) was passed in 1958 did this type of certification take hold nationwide. By 1967 more than 24,000 guidance counselors were trained under NDEA funding. The NDEA also mandated the establishment of criteria that would qualify schools to receive funds for the services of school counselors, which led to the rapid growth of certification (Sweeney, 1991).

National Board Certification

Many professional groups have initiated credentialing efforts at the national and the state levels to encourage excellence by promoting high standards of training, knowledge, and supervised experience. These standards promulgated by professional organizations may or may not be considered by governmental agencies, such as state departments of education or mental health, in relation to hiring and promotion requirements (Sweeney, 1991).

Similar to accreditation of counseling programs, the first counseling-related national certification addressed the specialty of rehabilitation counseling. During the late 1960s, rehabilitation counselors belonging to the National Rehabilitation Counseling Association and the American Rehabilitation Counseling Association (ARCA, an ACA division) began to work together toward establishing certification for rehabilitation counseling specialists (Forrest & Stone, 1991). Their efforts came to fruition in 1973, when the Commission on Rehabilitation Counselor Certification, known as CRCC, began to certify rehabilitation counselors (Forrest & Stone, 1991; Sweeney, 1991). CRCC designated more than 16,600 rehabilitation counselors as CRCs as of April 2016 (Cindy Chapman, CRCC staff, personal communication, April 22, 2016).

CRCC divides the criteria for certification as a CRC into several categories. Depending on the category under which the applicant is seeking certification, requirements include either a minimum of a master's degree in counseling (non-specified) or a master's degree specifically in rehabilitation counseling. In addition to the requirement of a master's degree, CRCs are required to have relevant supervised professional experience as a rehabilitation counselor (if the applicant did not graduate from a CORE-accredited program) and successful completion of the CRC examination (Cindy Chapman, CRCC staff, personal communication, April 22, 2016). The supervised experience requirement varies, depending on the type of degree earned by the applicant.

As previously noted, graduates of CORE-accredited programs are not required to have post-master's employment experience before applying to become a CRC. They do, however, need to complete an internship of 600 clock hours supervised by an on-site CRC or a faculty member who is a CRC. The internship must have been in rehabilitation counseling. Those who graduate with a master's in rehabilitation counseling from a non-CORE-accredited program must demonstrate the completion of an internship comparable to that in CORE-accredited programs and must have 12 months of acceptable employment experience under the supervision of a CRC (or complete a provisional contract). If applicants have a degree in rehabilitation counseling but do not have 600 hours of internship in rehabilitation counseling, they must have 24 months of acceptable employment experience, including a minimum of 12 months under the supervision of a CRC; if lacking the supervision by a CRC, they must complete a provisional contract. Individuals with related degrees as specified by CRCC may also pursue certification once they complete a post-graduate advanced certificate or degree and 36 months of acceptable employment experience with 24 of those under the supervision of a CRC (Cindy Chapman, CRCC staff, personal communication, April 22, 2016).

There also are eligibility criteria for individuals with master's degrees in counseling with an emphasis other than rehabilitation counseling who have had a minimum of one graduate course with a primary focus on theories and techniques of counseling. CRCC staff reviews applicants' transcripts to determine that they have had required courses. The employment requirements vary for these applicants, depending on the number of required courses they have taken. It is critical to understand that credentialing boards may revise eligibility criteria. We refer readers to the CRCC website, www.crccertification.com, for

additional information about specific requirements for individuals with master's degrees in counseling with a concentration other than rehabilitation counseling.

CRCC also offers certification to graduates of doctoral programs offering degrees in counseling or rehabilitation counseling. The applicant's transcript must include one integrated or two separate graduate-level courses in theories and techniques of counseling. Additional required coursework includes two or three graduate-level courses with the individual or combined focus on medical aspects of disabilities, psychosocial aspects of disabilities, and multicultural issues. Further, applicants need to complete a 600-hour internship at the doctoral level in a rehabilitation setting supervised by a CRC or 12 months of acceptable employment experience under the supervision of a CRC. In all these situations (master's and doctoral level), if applicants meet the employment criteria but lack supervision by a CRC, they must complete a provisional contract (Cindy Chapman, personal communication, April 22, 2016).

In 1979, the National Academy of Certified Clinical Mental Health Counselors (NACCMHC) was the next national counselor certifying body to be established. The NACCMHC merged with the National Board for Certified Counselors (NBCC) in 1992. As of July, 2016, the basic requirements to become a Certified Clinical Mental Health Counselor (CCMHC) included (1) completion of a master's degree or higher in counseling including a minimum of 60 graduate semester hours or 90 quarter hours in counseling in 10 specific content areas; (2) a minimum of 3,000 client-contact hours; (3) 100 clock hours of individual clinical supervision; (4) submission of an audio recording or video recording of a counseling session; and (5) successful completion of the CCMHC's Mental Health Counselor Examination for Specialization in Clinical Counseling (NBCC, n.d.). As criteria may change, we recommend that readers visit www.nbcc.org/Certification/ApplyForCertification for the most current information.

At the time of writing, NBCC is probably the most visible and largest national counselor-certifying body, with more than 61,100 active National Certified Counselors, or NCCs (Jolie Long, NBCC staff, personal communication, June 7, 2016). NBCC offers specialty certifications in addictions, clinical mental health, and school counseling. As of June 2016, there were more than 1,400 Certified Clinical Mental Health Counselors (CCMHCs), more than 600 Master Addictions Counselors (MACs), and more than 2,250 National Certified School Counselors (NCSCs) (Jolie Long, NBCC staff, personal communication, June 7, 2016).

The founding of NBCC offered the public a way to identify professional counselors who meet knowledge and skills criteria set forth by the counseling profession in the general practice of counseling. Being able to identify qualified counselors was especially important given the paucity of state counselor licensure laws at that time. The concept of a general practice of counseling is in line with CACREP's belief that there is a common core of knowledge shared by all professional counselors, regardless of specific areas of specialization.

As of June 2016, to be certified as an NCC, applicants must: (1) hold a master's degree or higher with major study in counseling, including a minimum of 48 semester hours or 72 quarter hours in graduate coursework; (2) demonstrate that their graduate coursework was from a regionally accredited institution and includes at least one course (carrying at least two semester/three quarter hours) in each of the required coursework areas; (3) have successfully completed at least six semester or 10 quarter hours of supervised counseling field experience; (4) provide two professional endorsements; and (5) pass the National Counselor Examination for Licensure and Certification (NCE) (or another NBCC examination, depending on the application type). Graduates of a

regionally accredited university must document at least 100 hours of post-master's counseling supervision and at least 3,000 hours of post-master's counseling work experience. (This requirement is waived for graduates with a CACREP degree.)

Counselors who have not graduated from a CACREP-accredited program must also document the completion of a minimum of 3,000 hours of work as a counselor over a maximum of 3 years since the date they received an advanced degree with a major study in counseling. Also, these individuals need to document that they received at least 100 hours of face-to-face counseling supervision over a minimum of 2 years, provided by a supervisor who holds an advanced degree in counseling or mental health field (social work, psychology, or marriage and family therapy) (NBCC, 2016a). Beginning January 1, 2022, NBCC will require a master's degree or higher from a CACREP-accredited counseling program. Individuals certified before January 2022 may hold the certification as long as they continue to adhere to NBCC policies and procedures. Current NCCs will still be able to apply for specialty certifications.

Licensure

According to the ACA (2016a), licensure is a credential granted or sanctioned by governmental bodies such as state legislatures that regulate either the title, practice, or both of an occupational group. Although states enact licensure laws as a means to protect the public from incompetent practitioners, such laws also provide benefits for the profession being regulated. The very fact that a state considers a profession important enough to regulate may lead to an enhanced public image and increased recognition for that profession. Also, more and more, being licensed has become necessary to be recognized and reimbursed by insurance companies and government and private mental health programs.

Just as certification can be confusing, so, too, can the concept of licensure. There are two primary types of licensure laws for counselors: title and practice acts (ACA, 2016a). States with practice acts require people to be licensed or to meet criteria for exemption from licensing noted in those laws to engage in specified counseling activities. Individuals in states with title acts must be licensed to refer to themselves as "licensed professional counselors" or use other counseling-related titles, but counselors may engage in the practice of counseling without being licensed. The majority of states have adopted practice acts for professional counselors (please see the section on Current Issues and Trends in Counseling in this chapter for additional information). Sweeney (1991) pointed out that it is essential to examine specific state laws and their accompanying regulations to determine the implications for practice. The ACA staff members assist counselors in this process by providing information about licensure requirements in each state and the District of Columbia on its website (www.counseling.org). In addition to using resources provided by the ACA, we strongly encourage practitioners to directly contact the regulatory boards in their states to determine if they need a license to practice counseling and what they may and may not call themselves. Contact information for state counseling boards is available the websites of the ACA (www.counseling.org/knowledge-center/licensure-requirements) and the American Association of State Counseling Boards (www.aascb.org/aws/AASCB/pt/sp/stateboards).

1970s in Virginia: The Beginning of Licensure for Counselors

Licensure of counseling practitioners, separate from psychologists, can be traced to the early 1970s. Before 1976, no state law defined or regulated the general profession of counseling.

This left the profession and professional counselors in a state of legal limbo—although counseling was not expressly forbidden (except where the laws regulating psychology specifically limited activities of professional counselors), it was not legally recognized as a profession either (Brooks, 1986). At that time, the American Psychological Association began to call for stringent psychology licensure laws that would preclude other professionals from rendering any form of "psychological" services. In Virginia, this resulted in a cease-and-desist order being served to John Weldon, a counselor in private practice in 1972 (Hosie, 1991; Sweeney, 1991). The Virginia State Board of Psychologist Examiners obtained a court order restraining Weldon from rendering private practice services in career counseling (*Weldon v. Virginia State Board of Psychologist Examiners*, 1972). The board claimed that Weldon was in fact practicing psychology, even though he presented himself as providing guidance and counseling services. In October 1972, Weldon was found to be practicing outside the law, but the court also ruled that the Virginia legislature had created the problem by violating his right to practice his chosen profession of counseling. The court proclaimed that personnel and guidance was a profession separate from psychology and should be recognized and regulated as such (Hosie, 1991). In response to the Weldon case, the Virginia legislature passed a bill certifying personnel and guidance counselors for private practice in March 1975. This law was amended by the Virginia legislature in 1976 and became the first general practice act for professional counselors.

At about the same time, Culbreth Cook, an Ohio counselor, faced a challenge similar to that of Weldon. Cook, well known and respected in his community, was employed at a two-year college and provided private educational assessment services on a part-time basis. Cook's education and training qualified him to offer the assessment services he rendered, but the police arrested him on the felony charge of practicing psychology without a license (Hosie, 1991). Carl Swanson, an attorney, counselor educator, and ACA Licensure Committee co-chair testified on Cook's behalf (Sweeney, 1991). The Cleveland Municipal Court judge refused to provide a restraining order against Cook, noting that even attorneys used the tools of psychology (*City of Cleveland, Ohio v. Cook*, 1975).

ACA leaders and staff have advocated for licensure of professional counselors since the 1970s. The Southern Association for Counselor Education and Supervision (SACES) (Hosie, 1991; Sweeney, 1991) created the first ACA licensure committee in 1973. The next year the ACA published a position statement on counselor licensure and, in 1975, appointed a special licensure commission. The commission distributed an action packet in 1976, including information about counselor licensure, the fourth draft of model state legislation, and strategies to pursue licensing (APGA, 1976). Model legislation offered a prototype for counselors in states that do not have licensure laws, in states that are in the process of revising their current laws, and where credentialing laws face sunset or legislative review (Glosoff, Benshoff, Hosie, & Maki, 1995). An additional goal of the model law was to facilitate the development of uniform standards for the preparation and practice of professional counselors across the United States, which is still a work in progress.

Progress Continues

Since ACA created the first model legislation for licensed professional counselors, ACA leaders have revisited and amended its model to reflect changes in standards within the profession and experiences in states that have implemented counselor licensure laws. An underlying philosophy of the ACA's model legislation is that state licensure laws legalize the general practice of counseling within each state, whereas the credentialing

of counseling specialists remains under the purview of professional credentialing organizations such as CRCC and NBCC.

The rate of licensure for counselors during the two decades between the time Virginia passed the first counselor licensure law, and the endorsement of ACA's 1994 model legislation has been seen by some to be painstakingly slow and by others as quite rapid. Brooks (1986) noted that "legislative successes were distressingly slow in the years following 1974" (p. 253). During the early 1980s, licensure took off when 15 states passed some form of credentialing acts between 1981 and 1986, 14 passed laws between 1987 and 1989, and 7 passed laws between 1990 and 1994 (Glosoff et al., 1995). Having counseling licensure laws enacted at that rate of progress is exceptional when compared with the 20 years it took the first 18 state psychology laws to be passed (Brooks, 1988). Since 1994, the profession has succeeded in having licensure laws enacted in all states, the District of Columbia, and Puerto Rico. In addition, a number of states passed amendments that brought previously existing credentialing laws more into line with the ACA's model legislation (for example, changing title acts to practice laws, expanding the scope of practice of professional counselors to include diagnosis and treatment of people with mental disorders, and increasing educational and experience requirements). We further discuss licensure in the next section on Current Issues and Trends in Counseling.

Current Issues and Trends in Counseling

In 2016, ACA celebrated its 64th anniversary, making the profession of counseling still relatively young as compared with other mental health professions. Professional counselors continue to respond to both the needs of society and the pressures from various socioeconomic factors—some of which led to the kaleidoscope we know as counseling today and others that will shape the future of the profession. These needs and pressures cut across the various specialty areas of counseling and cannot be categorized or delineated as neatly as in a historical review of the profession. For example, counselors continue to deal with issues related to the ongoing struggle for professional identity (including providing services across a continuum of wellness to pathology); licensure; the recognition and reimbursement of professional counselors both through private and governmentally based providers; managed care; effectively addressing multiculturalism, diversity, and social justice advocacy with and for clients (see Chapter 2); and technology (see Chapter 5).

Professional Identity

The American Counseling Association

In 2016, with 20 national divisions, 56 state and territorial branches, 4 regional assemblies, a myriad of divisional affiliates in each of the branches, and a membership of 55,875 members (Rae Ann Sites, personal communication, August, 2016), the ACA remains the strongest organization representing counselors on the national scene. It is not, however, without problems. ACA developed from a "group of groups," which has contributed to ongoing organizational challenges that stem from the groups' continued desire to have independence while working under an umbrella structure. Until 1998 the ACA bylaws required that members belong to ACA and one division. In October 1997, the governing council voted to amend the bylaws so that, effective as of July 1, 1998, ACA members could elect to join the ACA but not have to join a division. Also, division members were no longer required to also belong to ACA. This freedom of choice for

members has led to some interesting developments. In December 1999, 14 of the then 18 divisions (77.8%) opted to require their *professional members* (members with a master's degree in counseling) to belong to the ACA *in addition* to their division. As of August 2016, only 7 of the 20 divisions (35%) required *professional members* to also be members of the ACA. It is interesting to note that as of the writing of this text (August 2016), only approximately 25% of all ACA members belonged to a division (Denise Brown, personal communication, September 21, 2016). Do members consider themselves professional counselors first and specialists second or the other way around? One's professional identity may certainly influence divisional and ACA membership. At the same time, membership may be influenced by finances and what counselors can afford to pay for both association and divisional membership.

It is difficult to discern how policy makers (e.g., legislators and health insurers) view the structure of the ACA. To date, a "strength in numbers" philosophy has facilitated passage of legislation that has been important to the provision of counseling services and the recognition of professional counselors. It seems that all ACA entities, regardless of whether or not ACA membership is required, have managed to work together to have a positive influence on the passage of some key pieces of legislation since 1997, as noted in this chapter.

Chi Sigma Iota

Chi Sigma Iota (CSI) was formed in 1985 by Thomas J. Sweeney. Its mission is to "promote scholarship, research, professionalism, leadership, advocacy, and excellence in counseling, and to recognize high attainment in the pursuit of academic and clinical excellence in the profession of counseling" (CSI website www.csi-net.org/). With over 107,000 members, CSI, a member organization of ACA's 20/20 Committee, works to promote a strong professional identity through members (professional counselors, counselor educators, and students) (CSI website www.csi-net.org/).

20/20 Future of Counseling Oversight Committee

The ACA and AASCB established the 20/20 Future of Counseling Oversight Committee in 2005. This committee was composed of delegates from 31 counseling organizations including, but not limited to, all ACA divisions, CACREP, CRCC, CORE, and NBCC. The Committee representatives worked together from 2005 to 2013. An initial task for the Committee was to create a definition of counseling (as presented earlier in this chapter), which 29 of the 31 entities endorsed. As Kaplan, Tarvdas, and Gladding (2014) wrote, "having 29 out of 31 major counseling associations agree on a definition of counseling is historic" (p. 370) and represents a shift from counseling organizations working as a "group of groups."

The Committee's charge, however, went far beyond defining the profession of counseling. During the initial phase of the Committee's work, the representatives created a list of issues necessary to address to advance the profession (Kaplan & Gladding, 2011). These areas of focus included:

- Strengthening identity.
- Presenting ourselves as one profession.
- Improving public perception/recognition and advocating for professional issues.

- Creating licensure portability.
- Expanding and promoting the research base of professional counseling.
- Promoting client welfare and advocacy (Kaplan & Gladding, 2011, p. 369).

Building on the consensus list of issues, a sub-committee created a document, titled the *20/20 Principles for Unifying and Strengthening the Profession*, "that reflected the seven strategic areas" (Kaplan & Gladding, 2011, p. 370). The delegates than developed a list of over 25 strategies to achieve the principles. Please refer to Kaplan and Gladding (2011), "A vision for the future of counseling: The 20/20 principles for unifying and strengthening the profession," and to the "20/20: Passing the 20/20 Torch," posted on the ACA Knowledge Center website (www.counseling.org/knowledge-center/20-20-a-vision-for-the-future-of-counseling/concepts-for-future-exploration).

Wellness Orientation and Diagnoses

When examining the many laws that have been enacted related to the provision of counseling services, it is easy to see that professional counselors serve clients in a wide variety of work settings. These settings range from those focused on wellness and prevention of mental health problems to settings in which counselors diagnose and treat individuals with mental health disorders. Counselors are often thought of as traditionally working with well-functioning individuals and a "wellness" orientation not only remains the basis for many counselors' work, but also has been promoted in recent years (Lawson, Venart, Hazler, & Kottler, 2007). At the same time, counselors increasingly have been serving people with severe and chronic mental illness and addictions in hospital and community settings. Counselors working in community and clinical mental health agencies, rehabilitation facilities, substance or addictions treatment in out patient or residential facilities, and hospitals are expected to provide a variety of assessment, diagnostic, and counseling services with clients who exhibit a wide range of clinical disorders. There has been much discussion amongst professional counselors about the benefits and drawbacks of providing diagnostic services. For example, Seligman (2009) suggested that the use of a diagnostic system provides a framework for shared language or for describing mental disorders. In addition, this framework offers counselors a way to make sense of symptoms presented by individuals and to make decisions about the most effective ways to work with those individuals. Conversely, the use of diagnostic labels can add to stigma faced by people dealing with mental health issues. Further, the concept of diagnosis has traditionally been associated with a medical model that is inconsistent with wellness-based and developmental approaches to counseling that focus more on individuals' strengths and contextual and cultural influences in their lives (Seligman, 2009). This tension and the association of diagnoses with a medical model raises the question of whether counselors can diagnose individuals while maintaining a wellness orientation; can we assess and diagnose without embracing a medical model?

There are models of wellness that focus on working with clients holistically; attending to mind, body, and spirit and all aspects of their lives. For example, Myers and Sweeney (2004) offered a model of wellness that focuses on five life tasks: spirituality, self-direction, work and leisure, friendship, and love. Such models, coupled with clinical observations, provide a framework for describing the condition or symptoms of individuals. Most typically, however, counselors working in mental health, addictions, and rehabilitation facilities as well as others who work in managed care systems and tend to rely on insurance reimbursement, are required to provide diagnoses or diagnostic

impressions about clients using the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which is published by the American Psychiatric Association.

The DSM is currently in its fifth edition (*DSM-5*). According to the American Psychiatric Association (2013), the DSM attempts to use evidence-based criteria to present objective definitions for a wide variety of mental disorders. Further, in this edition, the multi-axis diagnosis was eliminated in favor of presenting diagnoses in a concise manner, which clinicians in different settings can more easily understand. During the 14-year revision process, the American Psychiatric Association, collaborating with the National Institute of Mental Health, the World Health Organization, and established working groups, created a DSM-5 Task Force composed of 29 members, and solicited feedback from other professionals through three rounds of public comments between 2010 and 2012 about potential revisions to the DSM (Dailey, Gill, Karl, & Barrio Minton, 2014). Although no member of the ACA served on the DSM-5 Task Force, Dailey et al. (2014) noted that the ACA did form its own DSM-5 Revision Task Force, advocating for professional counselors and providing feedback to the APA on concerns about specific areas in the proposed revisions. In addition to the change from a multi-axis diagnosis format, other key revisions to the DSM-IV-TR included increased sensitivity to cultural differences, improved diagnostic descriptions for children, and a more integrated approach to understanding mental health issues. These issues were among several points raised by ACA presidents Dr. Lynn Linde (2009–2010) and Dr. Don C. Locke (2011–2012) in letters sent to the APA DSM-5 Task Force chair and the APA president (Dailey et al., 2014).

As professional counselors continue to make strides in being recognized as qualified providers of services to individuals with diagnosable disorders, they will be hired in a broader array of community and hospital-based settings that will require them to use the DSM. Because of this we anticipate that there will be ongoing discussions regarding if it is possible, and if so how, to balance the profession's roots in developmental and wellness orientations and multiculturalism with marketplace and employment realities. As counselors serve an ever increasingly diverse clientele, and as many counselors adopt postmodern theories of counseling, we believe many professionals will view the use of the DSM as the primary diagnostic system as an issue of ethical advocacy, and will propose alternative diagnostic systems. Regardless of what diagnostic system counselors choose to use, it has been important that licensure laws include assessment, diagnosis, and treatment of persons with mental and emotional disorders as part of the scope of practice of licensed counselors.

Continued Progress in Licensure

In the 40 years since the passage of the Virginia certification law, all 50 states, the District of Columbia, and Puerto Rico have enacted some form of counselor credentialing legislation. It appears that counseling has made great progress in gaining recognition as a profession. For example, in 2016, 88.5% of the 52 jurisdictions with counselor credentialing laws were practice acts (ACA, 2016a) as compared with 53% of 43 jurisdictions in 1996. Another example of progress is that as of 2016, the majority of state licensing laws include language specifying that counselors who are licensed (at the highest level in those states with tiered licensure) can assess, diagnose, and treat persons with mental disorders. Some states include a caveat when discussing "assessment" in their licensure laws, noting that assessment by licensed counselors does not include the use of projective tests or individually administered tests of intelligence. It is critical to note

that scope of practice requires an interpretation of state licensing laws; this is not always an easy task as legislative language can be difficult to interpret at times. Because of this, readers should check with the licensing boards in their states to determine what services they may and may not provide.

The model legislation endorsed by ACA's governing body in 1994 is clearly a practice act and established a comprehensive scope of practice for LPCs, including the assessment, diagnosis, and treatment of persons with mental and emotional disorders. This scope of practice represents the broad continuum of services provided by professional counselors in the general practice of professional counseling and across specialty areas (Glosoff et al., 1995). The broadness of the scope is not meant to imply that all LPCs are experts in providing all services. Including a comprehensive scope of practice does, however, legally protect LPCs who are practicing within their scope of expertise. Without this protection, LPCs practicing within their scope of training (for example, career counseling, crisis intervention, or assessment) may find themselves, like John Weldon, legally prevented from rendering the very services for which they have been trained (Glosoff et al., 1995).

Although the counseling profession has achieved a great deal in the licensing arena, the state of licensure is confusing to many because the requirements vary from state to state. For example, in 2016, ten states and the District of Columbia had one tier of licensure. Other states had multi-tiered licensing, with different scopes of practice and different criteria for eligibility. Thirty-four states had two tiers of licensure (e.g., licensed professional counselor as a "basic license" and licensed clinical counselor as a more "advanced" license), six states had three tiers, and two states had four tiers of licensure (ACA, 2016a). Following are a few other examples of variances in licensing laws, as reported by ACA (2016a), which may be confusing to both counselors and policy makers.

- Educational requirements ranged from a master's degree with no specified number of hours to 60 semester hours including a master's degree, with 43 states and the District of Columbia requiring between 48 and 60 graduate semester hours (ACA, 2016a).
- Requirements for post-master's supervised counseling experience ranged from 500 (one jurisdiction) to 4,500 hours (four jurisdictions required between 4,000–4,500 hours) with the majority of states (35) requiring between 3,000–3,600 post-master's supervised counseling experiences, to be completed in no less than 2 years (ACA, 2016a).
- The titles granted to professional counselors by the regulatory boards vary. "Professional Counselor" is the most frequently used title, followed by "Mental Health Counselor," "Clinical Professional Counselor," and "Clinical Counselor." We believe a lack of uniformity in titles used by state-credentialed counselors has proven to be detrimental to credentialed counselors in their ongoing efforts to gain the same recognition afforded to psychologists and clinical social workers (ACA, 2016a).

In addition to the lack of uniformity in licensure requirements, or maybe because of it, there have been legal challenges regarding what professional counselors can and cannot do as part of their scope of practice. For example, although in 2016 approximately 85% of state licensure laws included that licensed counselors can assess individuals with mental disorders (ACA, 2016a), licensed counselors in several states have found themselves embroiled in legal battles over their ability to use standardized assessment instruments. The challenges have often been driven by efforts on the part of state psychological associations to proclaim that the use of most standardized tests comes under the sole

purview of doctoral-level psychologists. The tests noted by psychologists as requiring a doctorate in psychology to administer and interpret have run the gamut from personality tests to psychoeducational and career-related measures.

Counselors will continue to fight for their right to administer and interpret standardized instruments based on their education and training, rather than on the name of the degree they earned. Legislation proposed by several state psychological associations may serve to bring together master's- and doctoral-level counselors, social workers, marriage and family therapists, and speech therapists, who may all find themselves unable to legally provide testing services for which they are trained. Professional organizations such as the ACA, NBCC, CRCC, and several ACA divisions have taken an active role in challenging proposed and enacted legislation and in defending mental health professionals charged with practicing psychology without a license based on their use of standardized instruments for which they have been adequately trained.

Portability of licensure is another issue that impacts professional counselors. There is clearly a great deal of variance in licensure laws, often making it difficult for counselors licensed in one state to easily move to another state and become licensed. Many states that have practice licensure laws in place include a provision to obtain licensure through a review of credentials or endorsement. This review, however, is often cumbersome and time-consuming and still does not allow counselors to simply take their license with them from state-to-state. Professional counseling organizations have made strides in addressing the problem of licensure portability in our mobile society. As previously noted, one of the charges of the 20/20 Future of Counseling Oversight Committee was to create licensure portability by the year 2020.

In 2015, the AASCB sent a letter to all state counseling licensure boards recommending the following guidelines for the boards to approve applicants who hold a license in another state for licensure without an additional, and often time-consuming, review of education, supervision, and experiential hours:

> A fully-licensed counselor, who is licensed at the highest level of licensure available in his or her state, and who is in good standing with his or her licensure board, with no disciplinary record, and who has been in active practice for a minimum of five years post-receipt of licensure, and who has taken and passed the NCE or the NCMHCE, shall be eligible for licensure in a state to which he or she is establishing residence. The state to which the licensed counselor is moving may require a jurisprudence examination based on the rules and statutes of said state.
>
> (AASCB, 2015)

Also in 2015, the American Mental Health Counselors Association (AMHCA), the Association for Counselor Education and Supervision (ACES), and the National Board for Certified Counselors (NBCC) put forward a plan for licensure portability. There are a few key differences between AASCB's plan and the plan endorsed by AMHCA, ACES, and NBCC. The latter plan included a recommendation that states accept a license from another state when an applicant "holds a degree from a clinically focused counselor preparation program accredited by the Council for Accreditation of Counselling & Related Educational Programs (CACREP), holds certification as a National Certified Counselor, or meets standards adopted by the state board of counseling" (NBCC, 2016b). Also, the organizations called for 2, rather than 5, years of practice and clarified that their state boards could adopt criteria other than being a National Certified Counselor or

graduating from a counselor preparation program that was not CACREP-accredited (NBCC, 2016a).

Finally, given that the American Counseling Association is the largest counseling organization specifically dedicated to representing all counselors, the 2015–2016 Governing Council reviewed recommendations made by the presidential appointed Task Force on Portability. The Task Force examined both existing models and the long-term landscape of counseling. By an overwhelming majority, the Governing Council voted to adopt the ACA Portability Model, which states:

> A counselor who is fully licensed at the independent practice level in their home state and who has no disciplinary record shall be eligible for licensure at the independent practice level in any state or U.S. jurisdiction in which they are seeking residence. The state to which the licensed counselor is moving may require a jurisprudence examination based on the rules and procedures of that state.

Given the extensive training of counselors, the lack of research indicating that years of post-licensure practice mitigate ethical complaints, and AASCB's report that counselors undergo an average of 3,000 post-graduation hours of internship (AASCB, 2015), the ACA Governing Council approved the model. The goal was to remove barriers for fully independently licensed counselors, while remaining focused on client safety (Thelma Duffey, ACA President, personal communication, June 30, 2016).

Regardless of whether state licensure boards do or do not enact recommendations cited in either plan, both plans indicate continued collaboration across different organizations that represent professional counselors. We contend that such collaboration is necessary to achieve portability of licensure so that "licensed professional counselors across the country may provide the critical services for which they are trained, while at the same time creating a network of reciprocal relationships across the country" (AASCB, 2015).

Managed Care/Insurance

Counselors in a wide variety of work settings find themselves dealing with insurance and managed care companies. These companies have a great deal of influence on how health and mental health care providers, including counselors, provide their service. "Although managed care models have promoted accountability in treatment through an emphasis on quality over quantity of services, such models often fail to acknowledge critical differences in treatment needs related to specific issues or specific populations" (Calley, 2007, as cited in Gladding, 2013, p. 23).

One benefit of managed care and other forms of insurance is the emphasis on the accountability of practitioners, requiring providers to create (and often submit) counseling or treatment plans with clearly stated client goals and objectives. Providers often have to include the strategies or interventions they will use to help clients achieve their desired goals. The development of plans also provides counselors with a way to meet their ethical responsibility to monitor their effectiveness (ACA, 2014, C.2.d.). Many insurance companies further require providers to use evidence-based practices—to base their goals and interventions on research. Again, this aligns with the ACA *Code of Ethics* (2014), which calls for counselors to use interventions "that are grounded in theory and/or have an empirical or scientific foundation" (p. 10).

Although managed care has advanced the counseling profession by requiring accountability, it also has had negative ramifications for professional counselors and the

clients they serve. Decisions about the course of counseling are often based more on economics and a focus on short-term interventions with clients being limited in the number of sessions they can attend and having their needs met (Gladding, 2013). Similarly, counselors often feel frustrated in not being able to offer adequate treatment (Gladding, 2013) or being limited in the types of interventions that managed care companies will approve. Counselors often find that only certain diagnoses are covered, often affording clients with more severe mental health conditions being reimbursed or covered.

What happens when counselors know that if they submit an accurate diagnosis for some clients their services will not be covered? Do they submit a more serious diagnosis so that clients can receive services and have them paid for? If not, who pays for services? How do counselors balance their obligation to provide "proper diagnosis of mental disorders" (ACA, 2014, E.5.a., p. 11) with their integrity and the need to ensure that clients receive the services needed? These are just a few ethical concerns counselors face, along with issues of informed consent, confidentiality, maintaining records (Gladding, 2013), and developing competence in the use of short-term therapeutic modalities when working in managed care systems. To influence the policies that dictate who is approved to provide services and what services will and will not be covered, it is important for professional counselors to be appointed to serve on managed care boards (Gladding, 2013).

Recognition and Reimbursement of Professional Counselors

Credentialing has far-reaching ramifications for the hiring and reimbursement of professional counselors. Contrary to popular belief, credentialing affects the reimbursement of those professionals in settings other than private practice. Administrative rules used by several federal, state, and local agencies specify that agencies can employ only state-licensed practitioners. These same rules often stipulate that only licensed workers can supervise mental health services, and call specifically for licensed psychologists. In the late 1970s, Alabama eliminated all counselor position titles because of this type of thinking. Due to similar thinking, many university counseling centers will only hire licensed psychologists or clinical social workers. These are just a few examples of how credentialing has become strongly related to employment opportunities for counselors.

Reimbursement for services rendered has played a strong part in the licensure movement for all mental health practitioners. A motivating force in psychological licensing of the late 1960s and early 1970s was to secure third-party reimbursement and for practitioners to be included in national health insurance (Hosie, 1991). To facilitate these two goals, in 1975 the APA established the *National Register for Health Service Providers in Psychology* as a means of identifying qualified practitioners of psychological services. Since January 1, 1978, to be listed on the *National Register* one has been required to have obtained a doctoral degree in psychology from a regionally accredited educational institution. Even though advocates for professional counseling have argued that proficiency can be developed just as well in a counselor education department as in a psychology department, criteria for inclusion in the *National Register* clearly do not allow anyone who was trained outside of a psychology department to take the examinations for licensure or certification as psychologists in most states (Rudolph, 1986). This restriction had direct economic consequences for many doctoral-level professional counselors who were previously eligible to be licensed as psychologists. Having licensure laws for professional counselors in all states and the District of Columbia has been critical in influencing federal legislation and regulations that increase the likelihood of the hiring and reimbursement of professional counselors in a wide variety of settings.

Legislation and Employment

As we previously discussed, legislation has greatly influenced the development of the counseling profession, including the recognition of professional counselors and the reimbursement of services provided by professional counselors. In addition to achieving the enactment of licensure laws in all 50 states and the District of Columbia, counselors have made great strides in being recognized as providers of mental health services in many pieces of legislation enacted over the past 15 years. At the same time, the struggle and the need for ongoing advocacy in this area continues. Following are examples of current issues related to some key laws.

MEDICAID

Medicaid is a federal health care program created to provide coverage for individuals who are poor and underserved. The program is implemented through state regulations. Citing the Substance Abuse and Mental Health Services Administration, Bergman (2013) noted that Medicaid is the "largest payer for mental health services in the United States" (p. 63). The enactment of the 1997 Balanced Budget Act included provisions that prohibit Medicaid managed care plans from discriminating against providers on the basis of the type of license they hold. The Act, however, did not extend to fee-for-service plans regulated through Medicaid and most states have traditionally used these programs. Many states have recognized counselors as Medicaid providers. Those states all have managed Medicaid, rather than fee-for-service programs and the ACA and other organizations continue to fight the battle to include professional counselors as recognized Medicaid providers at the state level.

HEALTH PROFESSIONS EDUCATION PARTNERSHIPS ACT

As we previously noted, counselors were successful in their efforts to be recognized as qualified providers under the Health Professions Education Partnerships Act (HPEPA). HPEPA provisions directly influence the ability of counselor education programs to compete for clinical training grants by having graduate programs in counseling included in the HPEPA term "graduate program in behavioral and mental health practice." The act did not include a specific authorization level for any programs. Therefore, the passage of HPEPA does not, in itself, guarantee that counselors will be made eligible for any specific program but each time professional counseling is recognized in legislation is important.

The passage of HPEPA also resulted in the National Health Service Corps loan repayment program (ACA Office of Public Policy and Information, 1998b) including professional counselors. This program provides financial assistance in repaying student loans in exchange for working in health professions in underserved areas for 2 to 4 years following graduation (for example, serving in public inpatient mental institutions or federal or state correctional facilities or as members of the faculties of eligible health professions). Other programs authorized by HPEPA provide grants to schools to identify, recruit, select, and financially support people from disadvantaged backgrounds for education and training in health and behavioral and mental health fields, and grants to aid in the establishment of centers of excellence in health professions education for underrepresented minority individuals.

VETERANS AFFAIRS

As previously mentioned, Public Law 109–461, the Veterans Benefits, Healthcare, and Information Technology Act of 2006, included language clearly recognizing LPCs and licensed marriage and family therapists as mental health specialists within all health care programs operated by the Department of Veterans Affairs (VA). In September of 2010, the VA finally issued a qualification standard establishing the occupation of "licensed professional mental health counselor" within the agency. The occupational standard established these positions at the same salary and responsibility levels as for clinical social worker positions. The VA had long employed rehabilitation counselors but had not, until the enactment of this law, recognized counselors as mental health specialists. In addition to holding a license to independently practice mental health counseling, the VA criteria included graduation from a CACREP-accredited program (Bergman, 2013). The Institute of Medicine (IOM), which had been directed by Congress to study professional counselors as possible independent practitioners for military and veterans programs, proposed similar criteria. The IOM went beyond the suggestion of requiring a degree from a CACREP-accredited program to recommending the degree be "in mental health or clinical mental health counseling" and also requiring "passage of the NCMHCE" (Bergman, 2013, p. 65), which is necessary for certification by the NBCC as a National Certified Clinical Mental Health Counselor.

Although the IOM serves in only an advisory capacity to Congress and the U.S. Defense Department (DOD), Bergman (2013) pointed out that the recommendations made by the IOM will likely have an influence on the regulations that the DOD is in the process of crafting as well. The recommendations will also likely impact the occupational standards for mental health counselors, being written by the Office of Personnel Management (OPM) and that will be applied to other federally operated programs. These regulations will impact the hiring practices in VA programs, including TRICARE, and other government agencies. Several professional counseling organizations have advocated for what has been "typical" accreditation requirements for other mental health professions seeking employment in the VA, that being graduation from a regionally accredited institution of higher education. If graduation from a CACREP-accredited mental health program remains as a criterion for being hired in the VA, the number of professional counselors eligible for employment will be limited.

MEDICARE AND THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

As of 2016, Medicare had yet to include counselors as recognized providers except when providing services "incident to" the services of a physician or psychologists. Although the reauthorization of the National Defense Act in 2015 specified that licensed professional counselors who met specified criteria were recognized as independent practitioners under TRICARE, professional counselors are not yet recognized to practice independently as Medicare providers. This lack of recognition has indirectly had a negative impact on counselors being included as reimbursable providers of services under other public and private insurance programs. Although establishing Medicare coverage of counselors is no longer a new or controversial idea, deep concerns regarding federal budget deficits and the steep rise in Medicare spending projected over the coming years have made it difficult to win support for even modest increases in program spending. Because Medicare does not include professional counselors as independent providers in the federal statute, they have been unable to "sign off" on the delivery of mental health services through Medicare.

This inability, in turn, may deter administrators from hiring professional counselors. Counselor recognition under Medicare, when achieved, should go a long way toward evening the playing field for counselors in the health care provider marketplace.

Although there is still much work to be done for professional counselors to be fully recognized by the federal government and by state regulations governing the provision of mental health services, Bray (2015) reported that, in 2015, there had been a noticeable increase in the number of federal job listings open to professional counselors. The majority of those positions were to serve veterans and their families. It seems that the efforts to strengthen the professional identity of counselors, unify the profession, and have diverse counseling organizations collaborate on the passage of federal and state legislation have allowed professional counselors to make great strides.

Diversity of People Served by Professional Counselors

One of the most significant trends in relation to professional counselors' clients is that they reflect the diversity seen in today's society in terms of age, race, ethnicity, gender, and sexual orientation. It is more likely than not that counselors will work with clients who have different cultural backgrounds from their own. Also, individuals seeking counseling services do so for a wide variety of reasons. Professional counselors provide services to people who exhibit a full range of functioning, from healthy adaptation to pathology—from those seeking assistance with self-exploration to those individuals who are dysfunctional enough to require hospitalization. There is not enough space to comprehensively explore all of those work settings and types of services. The types of clients served by professional counselors are as diverse as the work settings in which counselors are employed. We provide below brief overviews of a few of the types of topics or issues that require attention from professional counselors.

Incarceration

According to the U.S. Department of Justice (Bureau of Justice Statistics, 2015), of the more than 1.5 million individuals incarcerated in state and local facilities in the United States, many have a mental illness or symptoms of a mental illness. Glaze and James (2006) reported that in 2005 close to one half of individuals incarcerated in federal and state prisons and local jails had reported mental health problems. These statistics are supported by more recent inmate census data (Bureau of Justice Statistics, 2015). It seems that our jails and prisons often are alternatives to mental health facilities for people who are homeless and have mental disorders and that individuals with substance abuse disorders are often being incarcerated rather than treated in the community. Mental health services clearly are needed in our jails and prisons. Also, there are often significant implications for the children and other family members of persons who have been incarcerated. Counselors have been active in providing these services as well as advocating for effective treatment for many years (note the IAAOC was established in 1974).

Veterans

A similar training issue exists in regards to counselors being adequately prepared to provide services to veterans. As previously discussed, the counseling profession has been strongly influenced by U.S. involvement in wars. Sadly, this continues today. Posttraumatic stress disorder (PTSD) and other mental health effects of combat can be seen in veterans years

after they return home. Clawson (2007), testifying before the President's Commission on the Care of Wounded Warriors, noted that approximately one in eight soldiers who fought in Iraq reported symptoms of PTSD and that more than one in three soldiers who served in combat in Iraq, Afghanistan, and other locations later sought help for mental health problems. These numbers may increase as members of the military have been required to serve for longer periods than ever before without significant breaks. In addition, although veterans do not seek service only through the Department of Veterans Affairs (VA), many do. With the passage of the Veterans Benefits, Healthcare, and Information Technology Act of 2006 and the 2015 recognition of mental health counselors as independent mental health providers under TRICARE, professional counselors need to be prepared to serve the mental health needs of military personnel and those of their of families and loved ones. In turn, this has implications for counselors and counselor education programs.

Traumatic Events

Military personnel are clearly not the only individuals to experience trauma. In addition to the more typical developmental types of crises with which clients often present, counselors are likely to come across clients who are dealing with trauma as a result of crises created by people or by nature. It is difficult to read a paper or listen to the news without hearing about violent crimes, car accidents, domestic violence, terrorist attacks, school shootings, police shootings of citizens and citizens' violence again law enforcement personnel, and natural disasters such as hurricanes, floods, earthquakes, and tornadoes. Cavaiola and Colford (2006) noted how common it is for individuals to feel overwhelmed and unable to cope with either being directly or indirectly affected by such events. It is not uncommon for survivors of major traumatic events such as the 9/11 World Trade Center attacks, Hurricane Katrina, and school/college shootings to suffer from symptoms of PTSD many years later, especially if they did not receive crisis counseling at the time of the event. Counselors need to be adequately prepared to provide crisis intervention as well as to work with long-term effects of trauma with both survivors of crises and first responders. In fact, the 2016 CACREP standards specify that counselors must demonstrate both knowledge and skills related to crisis intervention, including psychological first aid.

Older Populations

There also has been a marked increase in counseling services targeted at older individuals. This makes sense, given the "graying of America" shown by the steadily increasing average age of the population. According to the U.S. Administration on Aging (AoA, 2016), there were approximately 46.2 million individuals aged 65 or older in the United States in 2014. By 2060, the U.S. AoA (2016) estimates that there will be about 98 million older persons, more than twice their number in 2014. In 2015, a large percentage of older Americans were still in the labor force: 56% of men and 45% of women aged 62–64; 37% of men and 28% of women (up from 17% in 1993) aged 65–69 (Federal Interagency Forum on Aging-Related Statistics, 2016). Although a large number of older Americans are still in the labor force, we must consider that a number of these individuals are ready or will be ready to retire, and some would prefer to retire but remain in the labor force only because of economic needs. Given our strong roots in the career development area, this seems to be an excellent market for professional counselors. In addition to work-related issues, older adults are faced with mental health and substance abuse problems. For example, in a study by Richardson, Friedman, et al. (2012), 27% of older adults assessed

by aging service providers met criteria for having current major depression and 31% had clinically significant depressive symptoms. Further, according to Han, Gfroerer, Colliver, and Penne (2009), admissions for substance abuse treatment for people who were 50 or older increased by almost 50% between 2004 and 2009, yet the number of facilities offering specialized services to older adults decreased.

Serving Individuals Who Are Lesbian, Gay, Bisexual, Transgender, Questioning+ (LGBTQ+)

Sexual orientation and gender identification are not easily measured constructs, and individuals who are lesbian, gay, bisexual, transgender, or questioning (LGBTQ+) may be reluctant to identify themselves as such in surveys. Regardless, the results of several studies have strongly indicated that many individuals who are LGBTQ+ experience bullying and discrimination in their schools while growing up and in their workplaces as adults. For example, according to the Williams Institute (2007), since the mid-1990s there have been 15 studies in which 15 to 43% of LGBTQ+ respondents experienced discrimination in the workplace (e.g., being fired or denied employment based on their sexual orientation, being verbally or physically abused). In addition, 15 to 57% of people who identified as transgender reported experiencing employment discrimination. The 2013 National School Climate Survey conducted by the Gay, Lesbian, and Straight Education Network (GLSEN, 2014) indicated that of the 7,898 middle and high school students who responded to a survey, nearly three-quarters reported experiencing some form of harassment in schools in the past year due to their sexual orientation and about 55% of the participants reported feeling unsafe in schools due to their sexual orientation. More than 64% of student participants had heard derogatory remarks and name-calling such as "faggot" or "dyke" frequently in their schools, 74.1% were verbally harassed, 36.2% experienced physical harassment at school on the basis of sexual orientation, and 16.5% were physically assaulted. Although still high, the instances of different types of harassment appear to be on a downward trend. The results of the 2013 study further indicate that having supportive staff, such as counselors, makes a difference to students and is correlated with positive indicators such as a greater sense of safety, reports of missing fewer days of school, and a higher incidence of planning to attend college.

Counselors are likely to work with a client (child, adolescent, or adult) who is gay, lesbian, bisexual, or transgender. Although clients may or may not be open about their sexual orientation, and their sexual orientation may or may not be a primary counseling issue, counselors must be prepared to work effectively with individual clients who are GLBT and to advocate for the affirmation, respect, and equal opportunity for all individuals, regardless of sexual orientation or gender identity. To assist counselors, ALGBTIC developed Competencies for Counseling with Transgender Clients (American Counseling Association, 2010) and Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals (Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) LGBQQIA Competencies Taskforce, 2013).

Multiculturalism and Social Justice Advocacy

Although people from all cultures may encounter problems that counselors are trained to address, they experience these problems within a cultural context that counselors may not understand. The profession must determine the applicability of traditionally taught

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